BILLING CODE: 4410-09-P

DEPARTMENT OF JUSTICE
Drug Enforcement Administration

[Docket No. 11-1]
Morris W. Cochran, M.D.
Revocation Of Registration

On September 22, 2010, I, the then-Deputy Administrator of the Drug Enforcement Administration, issued an Order to Show Cause and Immediate Suspension of Registration to Morris W. Cochran, M.D. (Respondent), of Birmingham, Alabama. The Order proposed the revocation of Respondent's DEA Certificate of Registration BC1701184, and the denial of any pending applications to renew or modify his registration, on the ground that his "continued registration is inconsistent with the public interest." 21 U.S.C. § 824(a)(4).

More specifically, the Order alleged that while Respondent is authorized to prescribe Suboxone and Subutex "for maintenance or detoxification treatment pursuant to 21 U.S.C. § 823(g)(2) under DEA identification number XC1701184," he had "prescribed methadone," a schedule II controlled substance, "to patients for the purpose of drug addiction treatment" without the registration required under 21 U.S.C. § 823(g)(1). ALJ Ex.1, at 1-2.

Next, the Order alleged that Respondent had prescribed both methadone and Suboxone, the latter being a Schedule III controlled substance, to numerous patients whose charts show that he "did not obtain a prior medical history," that he "did not perform an initial physical exam," that he "established little or no basis for the diagnoses," and that he "offered no other treatment other than prescribing controlled substances." Id. at 2. The Order further alleged that "[s]uch prescribing was not for a legitimate medical purpose in the usual course of professional practice in violation of 21 CFR 1306.04(a), and in violation of Alabama Administrative Code 540-X-

11)(1), which requires that a physician personally obtain an appropriate history, perform a physical exam, make a diagnosis and formulate a therapeutic plan before prescribing drugs to a patient." Id. Finally, the Order alleged that Respondent had "continue to prescribe alprazolam, a schedule IV controlled substances depressant, to a patient after [the] patient file explicitly noted that the patient abused this drug." Id.

Based on the above, I concluded that Respondent's continued registration during the pendency of the proceeding "constitute[d] an imminent danger to the public health and safety." Id. I therefore invoked my authority under 21 U.S.C. § 824(d) and immediately suspended Respondent's registration.

Respondent requested a hearing on the allegations and the matter was placed on the docket of the Agency's Administrative Law Judges (ALJs). On November 2-4, 2010, an ALJ conducted a hearing in Birmingham, Alabama. ALJ Decision (also ALJ), at 3.

On January 5, 2011, the ALJ issued her decision which recommended that Respondent's registration be revoked. Id. at 51. Therein, the ALJ found that the Alabama Medical Board had not made a recommendation in the matter (factor one) and that Respondent has not been convicted of an offense related to the manufacture and distribution of controlled substances (factor three). Id. at 43, 48.

With respect to factors two (Respondent's experience in dispensing controlled substances) and four (Respondent's compliance with applicable laws related to controlled substances), the ALJ made extensive findings. First, the ALJ found that Respondent violated DEA regulations because he prescribed drugs other than Suboxone or Subutex on prescription forms that used only his Data Waiver (or X) number. ALJ at 43. The ALJ also found that

Respondent "improperly prescribed Suboxone for substance abuse using his regular DEA registration number rather than the required "X" number." Id.

Next, the ALJ found that Respondent prescribed methadone for detoxification and maintenance treatment without holding the separate registration required to do so under Federal law. ALJ at 43-45. The ALJ specifically rejected Respondent's testimony that he had prescribed methadone to nine patients to treat pain (which does not require a separate registration), noting that Respondent had initially told a DEA Investigator that he was prescribing methadone for detoxification purposes, that several patients who had received methadone had told the Investigator that they were being treated for substance abuse, and that several of the patients had come to Respondent's clinic "directly after" being treated by a methadone clinic "where the prescription of methadone for pain is prohibited" and had been diagnosed by Respondent as being substance abusers. Id. at 44-45. The ALJ also found that Respondent had violated the limitation imposed under Federal law and regulations which limit to 100, the number of patients who can be treated for substance abuse with Suboxone. ALJ at 46-47 (citing 21 U.S.C. § 823(g)(2)(B)(iii) and 21 CFR 1301.28(b)(1)(iii)).

Next, the ALJ found that Respondent violated both Federal and State regulations because his medical charts "fail[ed] to list the source and severity of pain when chronic pain [wa]s the diagnosis. ALJ at 47 (citing Ala. Admin. Code 540-X-4.08; 21 CFR 1306.04(a) and 1306.07(c)). The ALJ further found that Respondent's charts "fail[ed] to record when medical examinations were conducted and the specific results of those examinations in support of diagnoses," and that "[i]n some instances, patients actually reported that no examination was conducted." Id. The ALJ also found that the "charts failed to show the use of any treatment options besides the prescribing of controlled substances," and that the "lack of attempts of alternative treatment

modalities prior to determining that the patient suffers from chronic pain violates 21 CFR 1306.07(c)." Id.

The ALJ further found that Respondent had post-dated prescriptions for schedule II controlled substances in violation of Federal regulations. Id. at 47-48 (citing 21 CFR 1306.05(a) and 1306.12(b)). In addition, the ALJ found that Respondent had admitted to having issued a controlled substance prescription after he was served with the Immediate Suspension Order. Id. at 48. The ALJ then found that "Respondent testified, and the record contains no expert evidence to the contrary, that his treatment of his patients met the standard of care." Id. However, based on Respondent's improper use of his data-waiver number on prescriptions, his unauthorized prescribing of methadone for maintenance and detoxification purposes, his incomplete records, his failure to recommend any treatment options for his chronic pain patients besides the prescribing of controlled substances, and his issuance of a controlled substance prescription after his registration was suspended, the ALJ concluded that these factors supported the revocation of his registration. Id.

With respect to factor five – such other conduct which may threaten public health or safety – the ALJ found that Respondent lacked candor. More specifically, the ALJ noted that "[p]ractically all of the patient charts in this record had the same diagnoses: chronic pain and substance abuse. However, when most of the patients were asked about their treatment by the Respondent, they stated that they were being treated for substance abuse." Id. at 49. While the ALJ acknowledged "that it may be difficult to accurately diagnose chronic pain or substance abuse," she found Respondent's testimony that the patients did not know that they were being treated for chronic pain to "lack[] credibility." Id. The ALJ thus concluded that Respondent's "lack of candor also threatens public health and safety." Id. at 49.

The ALJ then turned to Respondent's evidence as to his remedial measures. The ALJ noted that Respondent had stopped using his X number improperly (to prescribe drugs other than Suboxone and for purposes other than substance abuse treatment), that he had stopped prescribing methadone, and that at the hearing, he had "apologized for the issuance of prescriptions for controlled substances without a proper DEA registration." Id. at 50. However, noting that upon being served with the Immediate Suspension Order, Respondent had stated that he did not intend to comply with it, as well as his testimony that while he currently lacks "authority to handle controlled substances, he continues to 'help' with the Suboxone at [another] clinic," the ALJ found that Respondent's "actions do not indicate remorse, but, rather, are more indicative of a failure to appreciate the seriousness of the allegations against him and the responsibility with which he was charged." Id. The ALJ further found that "Respondent, through his actions, likely facilitated" drug abuse. Id.

The ALJ thus concluded that Respondent had failed to rebut the Government's prima facie case. Id. at 51. She further recommended that Respondent's registration be revoked and that any pending applications be denied. Id.

Neither party filed exceptions to the ALJ's decision. Thereafter, the record was forwarded to this Office for Final Agency Action. Having considered the record as a whole, I adopt the ALJ's findings of fact and conclusions of law except as otherwise noted herein. I further adopt the ALJ's recommendation that Respondent's registration be revoked and that any pending application be denied. I make the following findings.

FINDINGS

Respondent is a physician licensed by the Alabama State Board of Medical Examiners (hereinafter, State Board or Medical Board) and is board certified in family practice. As of the date of the hearing, Respondent's state license remains current and unrestricted. Tr. 259. The State Board, however, has an open investigation of Respondent. Id. at 257-58.

Respondent is also the holder of DEA Certificate of Registration BC1701184, which prior to the issuance of the Immediate Suspension Order, authorized him to dispense controlled substances as a practitioner in schedules II through V, with the registered location of Narrows Health & Wellness, 151 Narrows Parkway, Suite 110, Birmingham, Alabama.[1] ALJ at 4 (stipulated facts). Respondent's registration does not expire until August 31, 2012. Id.

Respondent is also authorized to dispense Suboxone and Subutex, under the Drug Addiction Treatment Act of 2000 (DATA), for the purpose of treating opiate addicted patients and is authorized to treat up to 100 patients; Respondent has been assigned identification number XC1701184 for this purpose. Id.; see 21 U.S.C. § 823(g)(2). Suboxone and Subutex are schedule III controlled substances (and are the only schedule III through V drugs) which have been approved by the Food and Drug Administration for the treatment of opiate addiction by a DATA Waiver physician.

Respondent is not, however, authorized to dispense methadone, a schedule II narcotic, for the purpose of treating opiate addiction as he does not have the registration required by 21 U.S.C. § 823(g)(1). GXs 1 & 2. Respondent can, however, lawfully dispense methadone for the purpose of treating pain.

[1] Respondent also was practicing at offices in Red Bay and Russellville, Alabama. ALJ at 4-5 (Stipulated Facts at para. 4); Tr. 35.

The Investigation

Respondent first came to the attention of the authorities when several pharmacies complained to a State Board Investigator that he was prescribing large amounts of methadone using his X number. Tr. 35-36. The State Investigator passed this information on to a DEA Diversion Investigator (DI); on February 28, 2010, which was a Sunday morning, the two Investigators went to Respondent's Red Bay Clinic and arrived there at 6:30 a.m. Id. at 37. While the Investigators were in the parking lot taking photographs, they were approached by TS, who said "[h]e was waiting to get his methadone from" Respondent. Id. at 38. TS also stated that he paid cash for his visits, that he was seeing Respondent for an old football injury, that he did not provide any medical records to Respondent, and that he was not asked for identification when he first registered as a patient. Id. at 39-40.

Respondent did not arrive at the office until shortly before 11 a.m., by which time "close to 50 people" were waiting to see him. Id. The State Investigator then went inside to register in an attempt to see Respondent. Id. However, when the State Investigator was told that he would have to wait five to six hours to see Respondent, the Investigators decided to identify themselves and interview him. Id. at 42. Respondent initially told the Investigators that "he was operating a detox clinic where he was using methadone to get his patients onto Suboxone." Id. at 43. Respondent also said that he accepted cash only, that he saw an average of 80 patients on Sundays at the Red Bay clinic, and that he also treated chronic pain patients on whom he performed "range of motion tests." Id. at 43-44.

With respect to his chronic pain patients, Respondent told the State Investigator that he would look for surgical scars on the patient's body and that he sent some of his patients for X-Rays and MRIs. Id. at 218-19. Respondent admitted to the State Investigator that "he did not"

follow the Board's guidelines for the use of controlled substances in treating pain. Id. at 220. In the interview, Respondent also stated that he would require his substance abuse patients to undergo drug screens "if he felt that they needed one." Id. at 219.

Respondent also maintained that he knew the requirements for using his X number and that he was not prescribing any other drugs under this number. Id. at 44-45. The State Investigator then showed Respondent a methadone prescription he had written under his X number; Respondent said that the "prescription was a mistake." Id. at 45. The DI then told Respondent that he had found "close to 200 prescriptions . . . written under his X number for" drugs other than Suboxone and Subutex, including Xanax (a schedule IV depressant) and Adderall (a schedule II stimulant). Id.; see also id. at 221 (testimony of State Investigator).

The DI then asked Respondent how many patients he was treating under his X number. Id. at 46. Respondent said that he had 60 patients at his Red Bay clinic and another 50 patients at his Birmingham office. Id. When told by the DI that this exceeded the 100 patient limit, Respondent claimed that ten of the patients were actually being treated with Suboxone for pain. Id. at 46.

During the visit, the DI encountered JKB in Respondent's waiting room and asked to speak with him. Id. at 51. The DI asked JKB what Respondent was treating him for; JKB stated that he was treating him for an addiction to opiates with methadone. Id. at 52. JKB also told the DI that he had previously gone to a narcotic treatment program which used methadone and that he was going to Respondent because it was cheaper. Id. at 53. JKB also stated that he was not seeing Respondent for chronic pain. Id.

Following this interview, the DI resumed his interview of Respondent. Respondent now maintained that he was prescribing methadone for pain. Id. When the DI told Respondent that

he had just interviewed a patient who said he was being treated for opiate addiction with methadone, Respondent stated that the patient was mistaken. Id. at 54. When the DI reminded Respondent that he had earlier stated that he was using methadone to transfer patients onto Suboxone, he stated that he had previously misspoken and "[t]hat he was only using methadone for pain" and not to treat addiction. Id. at 55. When the DI asked Respondent whether it was possible to see eighty patients in a day and "provide the kind of treatment that was necessary for" them, Respondent stated that "he was overwhelmed and . . . needed some guidance." Id. at 56-57.

Upon leaving the clinic, the Investigators observed "approximately 50 patients inside of [the] office and probably another 50 to 60 . . . in the parking lot." Id. at 57. The Investigators then went to a local CVS pharmacy and interviewed its pharmacist, who stated that since the opening of Respondent's Red Bay clinic, he had "seen a tremendous spiking in the amount of prescriptions for methadone." Id. at 58. The pharmacist further stated that Respondent was writing methadone prescriptions to treat addiction and that he would not fill these prescriptions. Id. at 59; see also GX 7.

On May 17, 2010, the Investigators (along with a Supervisory DI) went to Respondent's Russellville office and obtained various patients files through either an administrative subpoena or a warrant. Tr. 48-50, 62-63. The Investigators again interviewed Respondent who stated that he was mainly seeing pain patients. Id. at 63. The DI then asked Respondent if he had made any changes to his practice; Respondent states that "he had switched pretty much everybody from methadone to Suboxone and that out of the 85 percent [of his] patients that he was seeing for pain, 95 percent . . . were being treated with Suboxone." Id. at 64. Respondent also stated

that he had stopped prescribing methadone for pain because he was having more success using Suboxone. Id. at 65.

During the interview, Respondent identified AK as a chronic pain patient who he was treating with Suboxone and who was waiting to see him. Id. at 65-66. The DI proceeded to interview AK, who had yet to see Respondent that day; AK stated that Respondent "was treating her for an addiction to opiates," and that after the February visit by the Investigators, he had stopped writing methadone prescriptions. Id. at 66.

The DI also interviewed another patient, SH, who was in the parking lot. Id. at 73-74. SH stated that Respondent was treating him for opiate addiction and not for chronic pain. Id. at 74.

The DIs seized 114 patient files which were selected on the basis of pharmacy records showing that Respondent had prescribed either Suboxone or methadone to the patients. Id. at 171-72, 174. The files were taken to the DIs' office where they were reviewed. Id. at 68. Thereafter, the DIs focused their investigation on approximately 28 patients, whose files were introduced into evidence.[2] During the course of the investigation, the DIs interviewed most of these patients by telephone to determine why they were seeing Respondent. Id. at 172.

The Patient Files and Interviews

Respondent's Methadone Patients

TP

On June 1, 2010, the DI spoke with TP. TP told him that Respondent did not physically examine her, that she paid $100.00 for the visit and that he prescribed methadone to her. Tr.

[2] Twenty-six of the patient files were entered into evidence as Government Exhibit 5; the two remaining files were entered into evidence as Government Exhibits 22-23. Respondent also introduced copies of the same files. See RXS 2, 4-28. I have carefully reviewed both sets of files and conclude that there are no material differences between the two sets.

103-105; GX 5X. TP went to Respondent because she had heard that he was using methadone to treat addiction. Tr. 105.

TP saw Respondent on three occasions (Feb. 7 and 21, and Mar. 7, 2010). GX 5X. TP completed an intake form on which she listed her medications as "methadone 12 10s a day" and wrote that her pharmacy was the "methadone clinic." Id. at 2. At her first visit, Respondent checked "YES" for whether TP had pain and listed her legs and back as the location. Id. at 3. Respondent diagnosed TP as having chronic pain, substance abuse and anxiety. Id.

However, Respondent did not document the nature and intensity of the pain, current and past treatments for the pain, and its effect on TP's physical and psychological functioning. Id. at 3, 5. No vital signs were recorded at any of her visits. Id. In addition, the chart contains no medical history. See generally GX 5X.

Moreover, while TP indicated that she had previously gone to a methadone clinic, Respondent did not know the name of the clinic and did not even attempt to obtain her treatment records. See generally GX 5X; Tr. 727-28. In addition, the progress note for TP's third visit contains no information other than her name, date of birth and the date of the visit.

At each of TP's three visits, Respondent prescribed a daily dose of eleven tablets of methadone 10 mg, with the first two prescriptions being written under his X number for 154 tablets each. See GX 5X. While TP told the DI that after DEA's February 28, 2010 visit, Respondent told her that he was no longer prescribing methadone, Tr. 105; on March 7, Respondent again prescribed 88 tablets of methadone 10 mg to her. GX 5X, at 1. When Respondent offered TP alternative medications to methadone, she elected to return to a methadone treatment program. Tr. 501, 728.

When asked on cross-examination if the methadone clinic which TP had previously gone to was treating her for abusing narcotics, Respondent testified that while the only purpose of a methadone clinic is to treat "substance abuse," she was "going for pain." Id. at 728. While Respondent also diagnosed TP as having substance abuse, he did not document the substances that she was abusing. GX 5X.

DG

DG first saw Respondent on January 3, 2010. GX 5O. On the intake form, DG listed his medications as "methadone." Respondent made a diagnosis of chronic pain even though he checked "NO" for whether DG had pain and the progress note for the visit does not document the nature and intensity of the pain, whether any treatments had been previously tried, and the pain's effect on his psychological and physical function. GX 5O, at 4. While Respondent noted that he performed a physical exam, he found each of the areas of the examination to be normal. Id. Respondent prescribed methadone to DG at this visit, as well as on January 12, 19, and February 1, 14, and 28, 2010. Id. at 5, 7, 9, 11.

On July 9, 2010, the lead DI interviewed DG. Tr. 106. DG stated that Respondent had told him on February 28, 2010, that he would no longer prescribe methadone, but that he would prescribe Suboxone to DG if he was having trouble getting off of the methadone. Id. at 107-08, 386.

Respondent testified that on January 19, 2010, he diagnosed DG as having a substance abuse problem, yet the medical chart does not document the basis for that diagnosis. Id. at 701-02. Respondent testified that his diagnosis was based on DG's demeanor and "probably . . . also a drug screen." Id. However, there is no drug screen in the file. See GX 5O.

DG testified at the hearing. The ALJ found credible his testimony that he was also seeing the Respondent for pain in his shoulder and lower back. ALJ at 23. While DG believed this pain was a result of masonry work he had done since he was a teenager, as well as a snowboarding accident he had when he had lived in Utah, DG's chart does not reflect any of this information. Tr. 367, 374; GX 5O.

According to DG, Respondent examined him and would spend about 7 to 10 minutes with him during his visits. Tr. 370. DG also denied having told the DI that Respondent did not perform a physical exam on him and that he was seeing Respondent for substance abuse. Tr. 371.

Respondent used his X number to prescribe methadone for DG. GX 5O, at 5, 7, 9, 11. The methadone prescriptions were for lesser and lesser amounts. GX 5O, at 1. In March of 2010, Respondent proposed to offer DG an alternative medication treatment plan. Id. at 11; Tr. 386-87. The medical chart stops at that point. GX 5O. Respondent stated that he believed his treatment of DG was appropriate. Tr. 488.

MB

On July 20, 2010, the lead DI interviewed MB. Tr. 108; GX 5A. MB stated that she was seeing Respondent for an addiction to Lorcet and not for chronic pain, that she paid cash for her prescriptions, and that Respondent did not perform any physical examinations. Tr. 109-110. MB also commented that she thought there were too many people waiting inside and outside the office to see Respondent. Id. at 109.

On the progress note for MB's first visit, Respondent circled "YES" for whether she had pain and diagnosed her as having chronic pain due to headaches. GX 5A, at 7. At the hearing, Respondent testified that MB was being treated for both periodic headaches and substance abuse.

Respondent did not, however, further document the nature and intensity of the pain, how it affected MB's ability to function, and any prior treatments for her pain. See id. Nor did he document the history of MB's substance abuse. Tr. 533-37. Respondent did not obtain information from MB's prior physicians. Tr. 533-34. While Respondent indicated that the physical examination was normal, he did not take MB's vital signs. Tr. 532-33; GX 5A, at 7.

Respondent described his treatment of MB as tapering her down on her methadone prescriptions, and the prescriptions show that Respondent was gradually reducing her daily dosage from 150 mg to 130 mg over the course of the slightly more than two months in which he treated her.[3] Tr. 463, 545, 550; GX 5A, at 5-6. At MB's last visit (Mar. 14), Respondent offered her the option of using different medication to control any potential withdrawal symptoms she may have from the lack of methadone. Tr. 464-65. However, MB chose to seek treatment elsewhere. Tr. 551.

Respondent issued MB two methadone prescriptions on his X prescription pad. Tr. 541-42; GX 5A, at 6. MB's file has no entry for her visits of February 28 and March 14, even though MB's drug log notes that a methadone prescription was issued on each date for 182 and 106 dosage units of methadone respectively. GX 5A, at 2-3.

JC1

Respondent saw JC1 three times in February and March of 2010. GX 5N. On his intake form, JC1 listed his medications as methadone and Xanax. GX 5N, at 2. On the progress note for JC1's first visit (Feb. 9), Respondent noted that he had been in an automobile accident and wrote "back" on the chart. Id. at 4. However, Respondent also noted that JC1 had "NO" pain and did not document the nature and intensity of the pain, details regarding the accident such as

[3] Respondent issued MB a total of six methadone prescriptions between January 5 and March 14, 2010. GX 5A, at 2. Some of the prescriptions indicated that they were "for pain." Id. at 4, 6.

when it occurred, what treatments had been used, and the pain's effect on his physical and psychological functioning. Id. The progress note indicated that Respondent did a physical exam, during which he did not find any area to be abnormal. Id. Respondent did not document having taken JC1's vital signs. Id. At this visit, Respondent gave JC1 prescriptions for 210 tablets of methadone 10 mg, with a daily dose of 15 tablets, and 60 tablets of Valium, even though he noted that JC1 was not agitated or moody and did not have insomnia. Id. at 4-5. These prescriptions were written under his X number. Id. at 5.

At JC1's next visit (Feb. 23), Respondent again indicated that he had "NO" pain and did a physical exam at which he found all areas normal. Id. at 4. At this visit, Respondent noted diagnoses of both chronic pain and substance abuse. Id. Respondent issued JC1 a prescription for 210 tablets of methadone 10 mg, with a daily dose of 15 tablets "for pain." Id. Respondent wrote the prescription under his X number. Id. at 5.

On March 9, Respondent wrote JC1 two more prescriptions, one for another 210 tablets of methadone with the same daily dose "for pain" as before, and one for twenty-eight tablets of Valium. Id. at 1, 7. Respondent wrote the prescriptions under his X number. Id. at 7. Respondent did not, however, create a progress note to document the issuance of the prescriptions. See generally GX 5N.

Respondent testified that JC1 had been in an automobile accident and had fractured his back, that he had developed a tolerance for pain medicine and was taking more and more, and thus went to a methadone clinic. Tr. 486. Respondent further testified that JC1 had come from either the Shoal's clinic or a narcotic treatment program in Hamilton because he "wanted to take a cleaner medicine for his pain." Id. at 486, 699. Respondent denied that JC1 had gone to the

narcotic treatment program "to be treated for addiction" and maintained that "he was going there to be treated for pain from a fractured back." Id. at 699.

As for the basis of the substance abuse diagnosis which he made at JC1's second visit, Respondent testified that "we probably got our February 9 drug screen back. And he probably had some [illicit] drug in there." Id. at 700. However, Respondent acknowledged that he was speculating about this because JC1's chart did not contain any drug test results. Id.

Respondent prescribed methadone at a lower dosage amount than the dosage JC1 reported he had been on. Id. at 486; GX 5N at 1, 5, 7. However, while Respondent maintained that JC1 "wanted to take a cleaner medicine for his pain," Respondent did not taper the methadone prescriptions for JC1, but rather prescribed the same daily dose of 150 mg in each prescription between February 9, 2010, and March 9, 2010. Tr. 486; GX 5N, at 1, 5, 7. When in March, Respondent offered him alternative medications, JC1 elected to go to another treatment facility. Tr. 486. Respondent maintained that his care of JC1 was appropriate. Id. at 487.

JB

Respondent treated JB in February and March of 2010.[4] GX 5L. On the intake form, JB listed his medications as "methadone," and on the progress note for his visit, Respondent wrote that JB had been a patient at the Shoals Treatment Center, that he had been on 230 mg. of methadone, but that he "was kicked out." GX 5L, at 5. Respondent further wrote that JB "desires to get off methadone." Id. In addition, Respondent noted that JB had foot pain, back pain and knee pain which had been caused by "a four-wheeler accident." Id.; Tr. 696. Respondent performed a physical examination and took JB's blood pressure and heart rate. GX

[4] It is unclear whether JB is the same person as JKB, who was interviewed in the waiting room on February 28, 2010, and who told Investigators that he had previously gone to a methadone clinic and that Respondent was treating him for opiate addiction, as the Government did not establish that this chart (GX 5L) was JKB's.

5L, at 5. Respondent also noted that JB had withdrawal, was agitated/moody, had insomnia, and had a positive MDQ (Mood Disorder Questionnaire). Id. Respondent then issued JB a prescription for a fourteen-day supply of methadone 10 mg, at a daily dose of 18 tablets, id., and noted that his plan included placing JB on his alternative medication (KCZZU) program. Id. Respondent issued JB a prescription for methadone, which was written under his X number, and wrote on it "for pain." Id. at 6. Respondent also wrote JB a prescription for Ultram, a non-controlled drug, on the same form, which listed only his X number. Id.

On February 28, 2010, JB again saw Respondent. Respondent circled "YES" for whether JB had pain and insomnia, and made a further notation that his pain was worse, although the precise area is illegible. Id. at 5. Respondent again noted a diagnosis of chronic pain and issued JB another prescription for 252 methadone 10 mg, with a daily dose of 18 tablets "for pain." Id. at 6. This prescription was also issued under his X number.

At JB's final visit (Mar. 14), Respondent noted that his "pain persists" and that he was "anxious about stopping methadone." Id. at 3. Respondent issued him a prescription for 156 tablets of methadone 10 mg with a daily dose of 17 tablets "for pain." Id. at 4. Respondent wrote the prescription on a form, which contained both his X number and regular DEA number. Id.

Respondent testified that JB had been asked to leave a drug treatment program before he saw the Respondent. Tr. 482. Respondent testified that he had done a drug screen on JB and that he did not "see anything that bothered [him], such as cocaine . . . or marijuana at that time." Id. at 483. However, JB's file does not contain the results of a drug screen. GX 5L.

According to Respondent, JB had been in a four-wheeler accident, took narcotics, and went to the drug treatment program because his other physician would not write anymore

prescriptions for narcotics. Tr. 696. Respondent did not, however obtain JB's records from the drug treatment program and Respondent maintained that the fact that JB was being treated at a methadone clinic did not tell him that JB was being treated for opiate addiction. Id. at 695-96. Respondent stated that he prescribed methadone in a tapered amount to prevent JB from going into withdrawal. Id. at 483; GX 5L, at 1.

Respondent also testified that he had provided JB with the option of other treatment medications, but that he elected to go to another methadone clinic. Tr. 483. Respondent annotated in the medical chart that he was treating JB for back and knee pain. GX 5L, at 5-6. Respondent did not document the severity of the pain. GX 5L. Respondent stated that his treatment of JB was appropriate. Tr. 483-84.

NB

Respondent saw NB three times in February and March of 2010. GX 5M. At her first visit (Feb.7), Respondent diagnosed her as having chronic pain even though he indicated that she had "NO" pain. GX 5M, at 3. Respondent did not document any further information regarding NB's condition (such as the nature and intensity of the pain, its history, whether any treatments had been previously tried, and the pain's effect on her psychological and physical functioning) at any of her three visits. Id. at 3, 5.

The progress note for NB's first visit indicates that Respondent performed a physical exam. Id. at 3. However, Respondent noted that all areas were normal. Id. Respondent did not document having taken NB's vital signs. Id. At this visit, Respondent issued NB prescriptions under his X number, for 210 tablets of methadone 10 mg (with a daily dose of 15 tablets) and 30 Xanax. Id. at 4. Respondent did not diagnose NB as having anxiety; indeed, he noted that she was not agitated/moody and did not have insomnia. Id. at 3.

On Feb. 21, Respondent issued NB additional prescriptions for methadone and Xanax under his X number. Id. at 4. The progress note for this visit, however, contains no information regarding her medical condition. Id. at 3. On the progress note for NB's final visit (Mar. 7), Respondent circled "CHRONIC PAIN" but made no other findings. Id. at 5. At this visit, Respondent issued her prescriptions for 112 tablets of methadone 10 mg, with a daily dose of 14 tablets "For Pain," and for 20 tablets of Klonopin "for anxiety." Id. at 6. Respondent wrote the prescriptions on a form which listed both his X number and his regular registration number. Id.

Respondent testified that NB told her at the initial visit that she had been on 180 mg of methadone and that "she was taking it for pain." Tr. 484. He then testified that "she also had some anxiety" and that she was a "troubling patient" because she was "on a combination of methadone and Xanax" which caused him great concern, especially if "those two drugs get mixed with alcohol." Id. at 485. None of this was documented.

Respondent also testified that he gave her "150 methadone," which was "much less methadone than she was on," and that he "gave her 28 tablets of the Xanax in fear of seizure potential if we went below that." Id. At her last visit, Respondent offered NB the option of alternative medications, after which she did not return to his clinic. Id. 485; GX 5M. Respondent believed his care of NB was appropriate. Tr. 485-86.

KI

Respondent saw KI four times in February and March of 2010. GX 5T. On the intake form, KI noted that her medications included "methadone, Xanex[sic], [and] Ambien." Id. at 2.

According to Respondent, KI was being treated at Shoals, a narcotic treatment facility, and she wanted out of the clinic. Tr. 494. Respondent testified that KI had back pain; however, Respondent indicated that she had "NO" pain on the progress note for her first visit. Tr. 494, GX

5T, at 3. Although Respondent wrote "Back" as the location, once again, he did not document the nature and intensity of the pain, the history of the pain, what treatments had been used, and the pain's effect on KI's physical and psychological functioning. GX 5T, at 3; Tr. 494, 718.

Respondent performed a physical examination but did not note any abnormalities; he also did not document having taken KI's vital signs. GX 5T, at 3. Respondent noted the diagnoses of both chronic pain and substance abuse and prescribed a lesser dose of methadone (130 mg per day) than what KI reported she had been receiving at Shoals (150 mg). Tr. 494; GX 5T, at 3-4. However, Respondent did not taper KI's methadone prescriptions; rather, he prescribed 130 mg per day of methadone to her three times between February 7, 2010, and March 7, 2010, with the first two prescriptions being written under his X number. GX 5T, at 1, 4, 6.

Respondent did not obtain treatment records from the narcotic treatment facility and did not know what substance KI was abusing; he also did not obtain any records related to her back pain. Tr. 715-16. Respondent testified that KI began taking narcotics to treat her pain, became addicted to those narcotics, but then denied that she had told him that she then entered the methadone clinic to treat her addiction. Id. at 716-17. Respondent testified that he offered alternative medications to KI, that on March 21, 2010, he refused to prescribe methadone to her, and that she then "went to another facility." Id. at 494-95. Respondent maintained that his care of KI was appropriate. Id. at 495.

Respondent's Suboxone Patients

SS

On June 1, 2010, the DI spoke with SS by phone. Tr. 96. SS said that he was being treated for opiate addiction, that he received a Suboxone prescription from Respondent, and that he was not being treated for chronic pain. He also stated that he paid $100.00 cash directly to

Respondent for his prescription and that Respondent did not conduct any examination on him. Tr. 95-98; GX 5H.

SS saw Respondent only on May 2, 2010. GX 5H, at 2-3. On the intake form, SS listed methadone as his medication and Respondent noted on the progress note that he was on 120 mg. Id. at 3. Respondent diagnosed SS as having both chronic pain and methadone use; while Respondent checked "NO" for SS's pain, he indicated that SS had disc surgery at L5S1. Id. at 3; Tr. 475. While Respondent recalled, and the chart reflects, that SS had back surgery, SS's chart does not contain any copies of records related to his back surgery and does not document the date of the surgery. Tr. 475, 673; GX 5H. SS's chart does not document the nature and intensity of the pain, current and past treatments for it other than the surgery, and the pain's effect on his physical and psychological functioning. GX 5H, at 3. No vital signs were recorded at SS's visit. Id.

Respondent testified that SS was on methadone, which he was getting "off the street," but that fact is not annotated in his chart. Tr. 672. Respondent, however, refused to prescribe methadone to SS. Instead, he prescribed Suboxone and offered SS the choice of an alternative medical treatment program for getting off of methadone. Id. at 475-76, 674. Respondent believed that he gave SS appropriate care. Id. at 476.

AG

On May 17, 2010, the DI interviewed AG. Id. at 80. AG stated that she was seeing Respondent for treatment of her addiction to Lortab, a schedule III narcotic containing hydrocodone. Id. at 80-81. AG further explained that she was not being treated for chronic pain, although such treatment was indicated in her chart. AG stated she did not know why her chart listed this condition. Id. at 81; see also GX 5P.

According to her chart, Respondent diagnosed AG as having chronic pain and substance abuse as a secondary condition. GX 5P, at 3; Tr. 488-89. However, the chart does not specify the basis for this diagnosis and Respondent checked "NO" for whether AG had pain. Tr. 704; GX 5P, at 3. In addition, Respondent did not record any vital signs at this or any subsequent visit.

Respondent prescribed Suboxone to AG at both the initial and several subsequent visits. Tr. 488; GX 5P, at 1, 4, 6, 8, 9. Moreover, at subsequent visits, Respondent continued to diagnose AG as having both chronic pain and substances abuse while checking "NO" for whether she had pain. See id. In other instances, the progress notes indicate that AG visited on a certain date but are otherwise blank even though Respondent issued AG a prescription. GX 5P, at 5. At AG's final visit, Respondent circled "YES" for whether she had pain but provided no further documentation as to the location of the pain, the nature and intensity of the pain, current and past treatment for pain, and its effect on her physical and psychological functioning. Id. at 7. In addition, the chart contains no medical history. See generally GX 5P. Respondent nonetheless maintained that he met the standard of care with respect to AG. Tr. 489.

LM

On June 1, 2010, DI Michael Jones interviewed LM by telephone. Id. at 82. LM stated that the Respondent was treating her for an addiction to pain killers. Id. at 83. Respondent had been treating LM since December 27, 2009, at the Red Bay clinic. LM confirmed that she was not being treated for chronic pain. Tr. 82-83.

LM completed a form in which she listed her medications as Adderall and Oxycontin, the latter being a schedule II narcotic. Tr. 193; GX 5V, at 2. At LM's first visit, Respondent diagnosed LM as having chronic pain, substance abuse, and bipolar disorder. GX 5, at 3. While

Respondent checked "YES" for whether LM had pain and listed her "back" as the location, the chart does not document the nature and intensity of the pain, current and past treatments for pain, and its effect on her physical and psychological functioning. Id. In addition, the chart contains no medical history. See generally id. Respondent prescribed Suboxone and Adderall on an X prescription pad. GX 5V, at 4, 6. Subsequently, he prescribed both controlled substances using his regular DEA registration number. GX 5V, at 6- 7.

At subsequent visits, Respondent continued to list chronic pain as a diagnosis while checking "NO" for whether LM had pain.[5] Id. at 3. Respondent testified that he was treating LM for back pain and for bipolar disorder. He further stated that LM was on Oxycontin and wanted to get "onto a better pain medicine." Tr. 498. However, when asked on cross-examination as to whether his diagnosis of substance abuse was "based on her abuse of Oxycontin," Respondent stated: "I think it had to do with – she had multiple things. She had stimulants . . . such as Adderall," and "I think she had taken periodically Xanax." Id. at 723.

LM's progress notes do not, however, indicate what substance(s) she was abusing. GX 5V, at 3 & 5. Moreover, notwithstanding his testimony that her substance abuse was based in part on her use of Adderall, Respondent prescribed this drug to LM at four of her subsequent visits. Id. at 4, 6, 7. Respondent believed his treatment of LM was within the standard of care. Tr. 498-99.

ET

On June 1, 2010, the DI interviewed ET by telephone. ET explained that the Respondent was treating him for an addiction to pain killers. Tr. 83-84. Respondent prescribed Suboxone to

[5] At LM's second visit, Respondent listed substance abuse as a diagnosis; however, at two subsequent visits, he no longer listed substance abuse as a diagnosis. See GX 5V.

ET on an X pad on four occasions between December 2009 and March 2010; in April, he prescribed Suboxone to ET on a prescription pad which listed both his X number and his practitioner's registration number. GX 5Z, at 4, 6, 8. ET told the DI that he was not being treated for chronic pain. Tr. 83-84.

The first two progress notes (one of which is undated but which is above the note for January 5, 2010[6]) indicate a diagnosis of chronic pain but not substance abuse, the latter not being listed as a diagnosis until ET's third visit (Feb. 2, 2010). GX 5Z, at 3, 7. Here again, Respondent noted on the chart that ET had "NO" pain and the chart does not indicate the location of the pain, the nature and intensity of the pain, current and past treatments for the pain, and its effect on his physical and psychological functioning. Id. at 3, 5, 7. No vital signs were recorded at any of ET's visits. Id . In addition, the chart contains no medical history. See generally GX 5Z. Respondent maintained that his care of ET was appropriate. Tr. 503.

CT

On June 2, 2010, a DI spoke with CT. CT stated that Respondent was treating her for opiate addiction with Suboxone. Tr. 87-88. On the intake form, CT listed her medications as "Suboxone, methadone, and Zanex [sic]." GX 5Y, at 2.

At CT's first visit, Respondent diagnosed her as having both substance abuse and chronic pain. GX 5Y, at 3. However, Respondent did not indicate in the chart what substance she was abusing. Id. Moreover, Respondent indicated that she had "NO" pain. Id. Respondent did not indicate a location of CT's pain until the third visit (approximately two months later) when he noted its location as her "back," but once again checked that she had "NO" pain. Id. at 5. While

[6] For this reason, I conclude that the undated note was for ET visit of December 8, 2009, at which Respondent issued him a prescription for Suboxone. See GX 5Z, at 1 & 4.

Respondent listed a diagnosis of chronic pain at each of CT's four visits, he never checked "YES" for pain on any of the progress notes. Id. at 3, 5. Respondent did not document the nature and intensity of the pain, current and past treatments for the pain, and its effect on CT's physical and psychological functioning. Id. Nor did he record vital signs at any of CT's visits. Id.

In his testimony, Respondent admitted that he did not know what substance(s) CT was abusing, but added that "usually they're on multiple medicines to get whatever desired effect they want." Tr. 729-30. Respondent did not obtain any prior treatment records for CT, whether for pain or substance abuse. Id. at 731.

Respondent wrote CT prescriptions for Suboxone on a pad which contained only his X number, as well as on a pad which contained both his X number and his regular DEA registration number. GX 5Y, at 4, 6. Respondent believed his treatment of CT was within the standard of care. Tr. 502.

JH

On June 2, 2010, the lead DI spoke with JH. JH stated that Respondent was treating him for "a bad addiction to Oxycontin" with Suboxone and that he was not being treated for chronic pain. Tr. 89-90; GX 5R. JH listed his medications as "OXY 80 mg x4." GX 5R, at 9. According to Respondent, JH was taking "four [Oxycontin] a day for his pain," which he was getting off the street because "his doctors fired him." Tr. 710.

At JH's first visit, Respondent diagnosed him as having substance abuse, attention deficit disorder and chronic pain. GX 5R, at 10. While in his testimony, Respondent maintained that JH had told him that he needed OxyContin "to get by with his pain," on JH's chart, Respondent indicated that JH had "NO" pain and did not document a cause of the pain. Id. Moreover, while

JH saw Respondent multiple times thereafter and diagnosed him as having chronic pain at each visit, Respondent never checked "YES" in the pain entry of the progress notes and never provided a description and location of the pain. See generally GX 5R. Moreover, Respondent never recorded vital signs for any of JH's visits. See generally id. Nor does JH's chart include a medical history. See generally id.

Respondent obtained a printout of JH's prescriptions from the State's prescription monitoring program. Id. at 2-8. While the report showed that JH had also obtained Suboxone from another physician (Dr. H.), Respondent neither obtained JH's records from Dr. H. nor conferred with him. Tr. 711-12; GX 5. Respondent wrote JH prescriptions for both Suboxone and Adderall under his X number. GX 5R, at 11, 15. However, Respondent required JH to undergo a drug test; while this test showed that JH was taking Suboxone (buprenorphine) and amphetamine (Adderall), he also tested positive for marijuana use. GX 5R, at 12. Respondent believed his care of JH was appropriate. Tr. 492.

KP

On June 2, 2010, the lead DI spoke with KP. KP stated that Respondent was prescribing Suboxone to treat her opiate addiction and that she was not being treated for chronic pain. Tr. 92-94. While Respondent testified that KP was on a narcotic which she wanted off of, KP did not list any medications she was on. GX 5W, at 2. Moreover, Respondent did not document the name of the narcotic in KP's record. Tr. 499.

Respondent testified that KP had "a complaint of pain." Id. At KP's first two visits (Dec. 6, 2009 and January 3, 2010), Respondent diagnosed her as having only chronic pain. GX 5W, at 3. However, for both visits, Respondent checked "NO" for whether KP had pain and did not list a cause or location of any such pain. Id.

Respondent did not make a diagnosis of substance abuse until her third visit (Jan. 19, 2010); however, none of the progress notes for KP's subsequent visits list a diagnosis of substance abuse.[7] See id. at 5, 7, 9, 11. Moreover, while Respondent continued to diagnose KP as having chronic pain, he did not check "YES" for whether she was having pain on any of the progress notes. See id. Nor did he document the cause, location or severity of her pain, or record her vital signs, at any of her visits. See id.

KP stated that she had to pay cash for her prescriptions as Respondent would not file a claim with Medicare for her. Tr. 94. She also stated that the Respondent did not perform any medical examinations on her, although Respondent indicated on the progress notes that he had done so and noted that the various parts of the examinations were normal (by either checking or lining through them). Tr. 95, see also GX 5W, at 3, 5, 9.

Respondent prescribed Suboxone and Xanax for KP on an X prescription pad. Id. at 499; see also GX 5W, at 4, 6. Respondent believed his treatment of KP was within the standard of care. Tr. 500.

TB

On June 10, 2010, the lead DI spoke with TB. TB stated that Respondent was prescribing Suboxone to him for both pain and addiction. Tr. 98-99; GX 5B. TB wrote on the intake sheet that he had used Suboxone, but Respondent did not know who prescribed it, and he commented that he could not tell from TB's chart if the Suboxone had been prescribed for substance abuse. GX 5B, at 1; Tr. 580-81.

At the first visit (Dec. 20, 2009), Respondent diagnosed TB as having chronic pain and substance abuse. Tr. 466. Respondent checked "YES" for whether TB had pain and indicated

[7] Respondent also diagnosed KP as having anxiety, for which he prescribed Xanax. GX 5W, at 5.

the location as the lumbar area. GX 5B, at 6. While Respondent testified that "[w]e got him to tell us about his back problems," if he had undergone any surgeries and how "it affect[ed] his everyday activity," Respondent did not document the nature and intensity of the pain, whether any treatments had been previously tried, and the pain's effect on his psychological and physical function. Id.; Tr. 578-79. Moreover, Respondent did not know if TB's back pain was caused by an injury or a degenerative condition. Tr. 578-79.

The chart indicates that Respondent performed an examination at which all areas including TB's back were found to be normal. GX 5B, at 6. However, no vital signs were recorded. Id. at 6-7. Respondent prescribed Suboxone to TB, as well as Ambien. Id. While Respondent testified that he prescribed the Suboxone for TB's back pain, he issued the prescription under his X number; he also issued the Ambien prescription on the same form. Id. at 7.

Respondent also saw TB on January 19, February 16,[8] and May 2, 2010. Id. at 4-7. At both the January and February visits, Respondent prescribed both Suboxone and Ambien to TB using his X number. Id. at 5, 7; Tr. 466-67, 587-88. Respondent did not obtain TB's records from other doctors even though TB listed Suboxone as one of his medications. Tr. 578-580; GX 5B. When asked if he knew the name of the doctor who had previously prescribed Suboxone to TB, Respondent testified "We might have found it out – I just didn't document it . . . . It could be a local doctor there." Tr. 581. When asked why TB had previously gotten Suboxone, Respondent could not definitively answer if it had been for pain or substance abuse. Id. at 582.

[8] In the progress note for this visit, Respondent indicated that TB had "NO" pain while continuing to indicate that he had chronic pain. GX 5B, at 4. In his testimony, Respondent explained he "marked off that [TB's] pain was controlled under the no part." Tr. 588. The ALJ did not, however, credit this testimony. See ALJ at 21-22. Nor do I.

With respect to the Ambien prescriptions, Respondent admitted that he did not document an insomnia diagnosis. Id. at 583.

SW

SW's chart indicates that he was being treated for chronic pain and substance abuse. While the chart for SW's first visit indicates that he was on Oxy 160 mg, Respondent checked "NO" for whether SW had pain and did not document the cause or severity of SW's pain. GX 5J at 3, 5. Respondent did not identify a potential source of SW's pain until his third and final visit, when he noted that SW had a herniated disc in his back and had undergone surgery. Id. at 3.

SW testified at the hearing and the ALJ found credible his testimony that he had a herniated disc in his back, that he had been taking Oxycontin for the pain, and that he had begun treatment with the Respondent in order to get a different pain medication. Tr. 346. The ALJ also found credible SW's testimony that he told a DI that Respondent was treating him for chronic pain and that the Respondent had performed a physical examination on him.[9] However, the ALJ also found credible SW's subsequent testimony that he had told the DI that he was being treated for substance abuse because "it was better being on Suboxone than it was Oxycontin." Tr. 363.

Respondent did not know who had prescribed Oxycontin to SW, and SW's chart does not contain any prior medical records. Tr. 684-85; GX 5J. SW testified that he was addicted to his pain medications. Tr. 355. Respondent spent 15 to 20 minutes with SW and prescribed Suboxone to him. Id. at 351-52; GX 5J. SW testified that he had an MRI in 2005 or 2006, and a

[9] The ALJ noted that the testimony of the lead DI and SW conflicted on this point. ALJ at 22 n.3. The DI testified that SW told him that Respondent was not treating him for chronic pain and had not performed a physical examination on him; SW testified to the contrary. Compare Tr. 102-03, with id. at 348-49. The ALJ found, however, that the DI had difficulty recalling the conversation that he had with SW and his memory had to be refreshed by the use of his notes, id. at 101-102, but that SW's memory required no similar refreshment. Id. at 345-65. I therefore adopt the ALJ credibility finding that SW's testimony is a more reliable account of the conversation that took place between SW and the DI.

bone scan in 2001 or 2002, but these test results were not part of his patient chart in evidence. Tr. 346, 349, 353, 357; GX 5J.

SW saw Respondent three times. See GX 5J.[10] At the time of the hearing, SW was still taking Suboxone, but he was not getting it from Respondent. Tr. at 364-65. Respondent refused to file an insurance claim for SW, and required that he pay $100 cash for the visits. Id. at 102-103.

CL

CL first saw Respondent on December 20, 2009. See GX 22, at 6. Respondent made a diagnosis of both chronic pain and bipolar disorder; however, Respondent did not document the nature and intensity of the pain (he did not check either "YES" or "NO" for whether CL had pain), the history of the pain, whether any treatments had been previously tried, and the pain's effect on her psychological and physical function. Id. While Respondent noted that he had performed a physical exam and found all areas normal, he did not record any vital signs. Id. Respondent did not make a substance abuse diagnosis at this visit and yet prescribed Suboxone to CL under his X number. Id. at 7.

Respondent saw CL again on January 17, 2010. Id. at 6. At this visit, Respondent again diagnosed CL as having pain even though he noted that she had "NO" pain and made none of the findings as explained above. Id. He also diagnosed her as having substance abuse and required that CL undergo a drug screen, the results of which are not in her chart. Tr. 127-28, 153-54; GX 22. Respondent did not, however, document CL's history of substance abuse. GX 22, at 6. Respondent again provided CL with a prescription for Suboxone. Id. at 7.

[10] SW testified that he saw Respondent four or five times. Tr. 364. However, SW's patient file documents only three visits.

Respondent provided CL with prescriptions for Suboxone on February 14, March 14, April 10, and May 9, 2010. Id. at 2-3, 5. However, the progress notes for both February 14 and March 14 contain no information besides CL's name, date of birth and the date of the visit. Id. at 4. The progress note for April 10 indicates that CL had chronic pain even though Respondent checked "NO" for her pain and no longer listed substance abuse as a diagnosis. Id. at 1. Finally, the progress note for CL's last visit (May 9) again lists chronic pain as one of three diagnoses even though Respondent checked that she had "NO" pain. Id. While the notes for both the April 10 and May 9 visits indicate that CL's physical exam was normal, Respondent did not document having taken any vital signs as either visit. Id.

CP

The earliest progress note for CP is dated December 20, 2009, which also corresponds with the earliest date listed on the record of CP's Suboxone prescriptions. GX 23, at 5, 10. The progress note indicates a diagnosis of chronic pain, even though Respondent checked that CP had "NO" pain and contains no other documentation (such as the nature and intensity of the pain, its history, and its effect on CP's functioning) to support this diagnosis. Id. at 5. Respondent also diagnosed CP as having substance abuse (with no supporting findings) and anxiety. Id. While Respondent performed a physical exam and found all areas normal, he did not document having taken CP's vital signs. Id. Respondent prescribed Suboxone and Xanax at this visit using his X number.

At the next visit, Respondent again noted that CP had chronic pain while indicating that he had "NO" pain. Id. Respondent, however, made an entry in the blank for "EXT" and for the "Location," both of which are illegible. Id. Respondent did not, however, note a diagnosis of substance abuse at this or any subsequent visit. See generally id. at 1,3,5.

At CP's next visit (Feb. 16), Respondent again diagnosed him as having chronic pain while noting that he had "NO" pain. Id. at 3. Subsequently, at CP's April 10 visit, Respondent again checked that CP had "NO" pain while writing "knee pain" in the "Review of Systems" section; he also made a note next to the "EXT" section of the Examination which is illegible but was not asked about this during his testimony. Id. Finally, at CP's final visit, Respondent again diagnosed him as having chronic pain but noted that he had "NO" pain and did not otherwise document any other findings regarding CP's pain. Id. at 1. Moreover, the Government did not offer any testimony as to whether it had interviewed CP.

Respondent issued CP prescriptions for Suboxone on Dec. 20, 2009, Jan. 17, Feb. 16, Mar. 16, April 10, and May 9, 2010; he also wrote CP prescriptions for Xanax on each of these dates except for April 10. GX 23. Respondent wrote both the Suboxone and Xanax prescriptions on Dec. 20, 2009, as well as the Jan. 17, Feb. 16, and March 16, under his X number. Id. He also wrote the April 10 Suboxone prescription under his X number even though he did not list a diagnosis of substance abuse on any of CP's visits after the first visit. Id; Tr. 130-31.

CML

On June 23, 2010, another DI interviewed CML and asked whether she was "being treated for pain or addiction." Tr. 266-67. CML stated that she was being treated for addiction to controlled substances and that the Respondent was prescribing Suboxone to her. Id. at 267-68. She paid $100.00 cash for her visits. Id. at 268.

On the progress note for CML's first visit (Dec. 8, 2009), Respondent checked that she had both pain and chronic pain, as well as insomnia. GX 5F, at 7. While Respondent noted that her physical exam was normal in all areas, he did not record any vital signs and did not

document the nature and intensity of the pain, the history of the pain, whether any treatments had been previously tried, and the pain's effect on her psychological and physical function at any of her subsequent visits. See GX 5F. Respondent did not document that CML had back pain until her sixth and final visit (April 27, 2010), while on the same note checking that she had "NO" pain. Id. at 3.

Indeed, several of the progress notes for CML's visits contain no medical information whatsoever. With respect to this, Respondent testified, "In fact, there's some entries I didn't even put in on February and March of 2010 and I don't know why that's the case." Tr. 472.

At CML's second visit, Respondent noted a diagnosis of substance abuse. GX 5F, at 7. However, Respondent did not note this diagnosis at any of CML's subsequent visits. See GX 5F. Moreover, the chart contains no information about what substances CML was abusing and her history of substance abuse. GX 5F, at 7; Tr. 666.

Respondent admitted that the chart fails to adequately document CML's pain. Tr. 472. Respondent also testified that he was tapering CML's dosages of Suboxone to find the appropriate levels to treat her chronic pain. Id. at 473. Respondent maintained that his care of CML was within the standard of care. Id. Respondent prescribed Suboxone (and Ambien at the first visit) to CML under his X number at several of the visits even though he did not document that he was treating her for substance abuse at those visits. See GX 5F.

SJW

On December 29, 2009, SJW made her initial visit to Respondent.[11] GX 5I, at 7. At the visit, Respondent diagnosed SJW as having both chronic pain and substance abuse, although he noted that she had "NO" pain and did not document the nature and intensity of the pain, the

[11] SJW's file includes an intake form in which she listed her medications as "Suboxin." GX 5I, at 1.

history of the pain, whether any treatments had been previously tried, and the pain's effect on her psychological and physical function at this or any of her subsequent visits. Id. While Respondent indicated that all areas of her physical examination were normal, he did not record any vital signs at this visit. Id. Nor did Respondent make any notes regarding SJW's history of substance abuse. There is, however, no evidence that Respondent prescribed to SJW at this visit.

Respondent did, however, prescribe Suboxone (and Xanax) to SJW at her second visit, which occurred one week later. Id. at 7-8. On the progress note for this visit, Respondent listed the diagnoses as chronic pain (while indicating that she had "NO" pain and failing to document any other information regarding her condition) and substance abuse, again without any documentation. Id. at 7. Moreover, he again documented that SJW's physical exam was normal but did not record any vital signs. Id. Nor did Respondent document that SJW had anxiety, the condition for which Xanax is typically prescribed, and, in fact, Respondent indicated "NO" for whether she was agitated/moody. Id.

While SJW's chart shows that she received prescriptions for Suboxone (and Xanax) in February and March, the progress notes for this period contain no information regarding her medical condition(s). Id. at 2, 5-6. Regarding these incidents, Respondent stated: "I don't have an explanation for it unless I had to zip over and take care of another patient and I just took care of her and then took off. I don't know the situation." Tr. 681.

On May 9, 2010, SJW made her final visit to Respondent. GX 5I, at 3. At this visit, Respondent again diagnosed her as having chronic pain while indicating that she had "NO" pain and that her physical examination was normal in all areas. Id. at 3. Respondent also diagnosed

her as having anxiety, even though he indicated "NO" for whether she was agitated or moody. Id. Respondent issued her prescriptions for both Suboxone and Xanax. Id. at 4.

On June 23, 2010, a DI phoned SJW and interviewed her. SJW told the DI that Respondent was treating her for her addiction to controlled substances and that she paid $100 cash for each visit. Tr. 268-69. On two occasions (Jan. 5 and Feb. 2), Respondent prescribed both Suboxone and Xanax to SJW under his X number. Tr. 269; GX 5I, at 6, 8. Respondent testified that he was treating SJW for pain and anxiety. Tr. 477, 679.

As for how he made his diagnosis of substance abuse, Respondent testified that "[i]t could be in her history with me; it could be a drug screen." Id. at 679. There is, however, no evidence in SJW's chart establishing that Respondent took a history or that he required her to undergo a drug screen. See generally GX 5I. Moreover, when asked "do we see an indication that [SJW] complained of pain?," Respondent answered: "No. I did not fill that out." TR. at 679-80. As for Respondent's failure to note why he prescribed Xanax, Respondent testified: "No, I did not put an anxiety there. And there was a good chance that she was on Xanax already. Did not give it to her in the December because she probably already had an active prescription for it. And we probably got that from the drug monitoring system." Id. at 680. Respondent believed his treatment of SJW was appropriate, but that his documentation was "terrible." Tr. 478.

LMJ

On her intake form, LMJ listed her medications as "Loricets" [sic]. GX 5E. At her first visit (Feb. 16, 2010), Respondent made diagnoses of both chronic pain and substance abuse. Id. at 4. However, Respondent noted that LMJ had "NO" pain, that her physical examination was normal and did not document the nature and intensity of the pain, the history of the pain, whether

any treatments had been previously tried, and the pain's effect on her psychological and physical function at this visit or her next two visits. Id. at 2 & 4. Respondent did not note a location of any pain LMJ had until her final visit; even then, however, he did not document any information other than that the pain was in her "back & arms." Id. at 2. Respondent did not document having taken LMJ's vital signs at any of her visits. Id. at 2, 4. Moreover, while at LMJ's first three visits, Respondent listed a diagnosis of substance abuse, the chart contains no information as to her history of substance abuse. Id. at 2, 4. At each of LMJ's visits, Respondent prescribed Suboxone to her. Id. at 3, 5.

On June 24, 2010, a DI interviewed LMJ by phone. Tr. 270. The DI asked LMJ whether she was seeing Respondent for pain or for addiction to controlled substances; LMJ said that she was seeing Respondent for addiction for which he was prescribing Suboxone. Id. LMJ also stated that she paid $100.00 cash for each visit. Id.

The ALJ found that Respondent credibly testified that he did not "have a good grasp on her history and physical as to, is this chronic pain or substance abuse, so we put the differential as both of these right now." Id. at 470. She also found credible Respondent's testimony that LMJ was a patient "who wanted to get off Lorcet because she was building such a tolerance having to take more and more of this for her pain, but I could not totally rule out that she had a substance abuse problem." Id. at 471. While Respondent testified that he could sometimes rule out a substance abuse diagnosis "later on as [I] get a grasp on these patients, and periodic random drug screens help me with this also," there is no evidence that Respondent required LMJ to undergo a drug test. Id. Respondent thought his treatment of LMJ was within the standard of care. Id.

MR

MR first saw Respondent on December 15, 2009. GX 5G, at 7. Respondent diagnosed MR as having chronic pain even though he noted that MR had "NO" pain. Id. Respondent documented the pain's location as MR's "Teeth" and prescribed Suboxone to him. Id. at 7-8. Respondent testified that MR's pain was in his mouth and jaw, but the chart does not contain any other information regarding this condition. Tr. 474, 668; GX 5G. Moreover, Respondent continued to list a diagnosis of chronic pain at MR's visits of Jan. 17, Feb. 14, and Mar. 30, even though on the respective progress notes, he checked "NO" for whether MR had pain, did not list a location of the pain, noted that the physical exam was normal in all areas, and did not document having taken any vital signs Id. at 5, 7. Nor is there any evidence that Respondent referred MR to a dentist.

On both the January 17 and March 30 progress notes, Respondent also listed a diagnosis of substance abuse. Id. at 5, 7. However, Respondent did not document the basis for his diagnosis. Id. At MR's final visit, Respondent no longer listed a diagnosis of substance abuse. However, he now documented that MR had right shoulder pain as the result of a motor vehicle accident. Id. at 3; Tr. 671. Respondent testified that MR had gone to the emergency room, but that he had not obtained those records. Tr. 671.

When asked whether MR's tooth pain "was no longer an issue in the subsequent visits"; Respondent maintained that "I just didn't enter it." Id. at 672. As for the diagnosis of substance abuse, Respondent did not note in MR's chart the substances he abused, and Respondent could not remember during his testimony.[12] Id. at 668-69; GX 5G.

[12] The ALJ found credible Respondent's testimony that he had also diagnosed MR with bipolar disorder, but that he had failed to annotate that in the patient's chart as well. Tr. 474.

On June 24, 2010, a DI phoned MR and interviewed him. Id. at 271. The DI asked MR whether he was seeing Respondent for chronic pain or for addiction; MR stated that "he was addicted." Id. at 271-72. MR also said that he paid $100.00 cash for each visit. Id. at 272. MR was treated with Suboxone, which was written on an X prescription pad. Tr. 474; GX 5G, at 6, 8. Respondent believed his treatment of MR was appropriate. Tr. 475.

SHY

SHY first saw Respondent on December 13, 2009. GX 5D, at 8. On the intake form, SHY listed his medications as Suboxone and Zyprexa. Id. at 1. Respondent diagnosed SHY as having chronic pain even though he circled "NO" for whether SHY had pain, did not note the location of the pain, and did a physical examination during which he found all areas normal. Id. at 8. Moreover, Respondent did not document a history of the pain, whether any treatments had been previously tried, and the pain's effect on his psychological and physical function at this visit. Id. Respondent also did not document having taken SHY's vital signs.[13] Id.

At SHY's subsequent visits, Respondent continued to document that SHY had chronic pain even though he repeatedly noted that he had "NO" pain, never found anything that was not normal during the physical exams, and never listed a location of any pain. Id. at 4, 6. Respondent also noted a diagnosis of substance abuse on two separate occasions, but did not document SHY's history of substance abuse and what substances he was abusing. Id. He did, however, require SHY to undergo a drug screen at the first visit, the results of which were negative with the exception of the test for synthetic opioids, which was consistent with SHY having indicated that his medications included Suboxone. Id. at 1, 10-11.

[13] Respondent also diagnosed SHY as having major depression.

On June 22, 2010, a DI called SHY, and asked him why he was seeing Respondent. Tr. 288. SHY said that he was being treated for opiate addiction and that he was not being treated for chronic pain. Id. at 288-89.

At the hearing, Respondent testified that he thought SHY was probably abusing either Lorcet or Oxycontin. Id. at 659. However, he then admitted that he did not document this. Id. Respondent then claimed that SHY "probably had a little marijuana or something like that in a drug screen, and that's where we probably gave him a substance abuse diagnosis." Id. at 660. SHY did not, however, test positive for THC. See GX 5D, at 10-11. Respondent also admitted that he "did not document . . . any details of the pain," but then stated that "[a] lot of these people with major depression have pain from the depression, but we still put a diagnosis of potential chronic pain." Id. at 468, see also id. at 655-56. Respondent acknowledged that he inappropriately prescribed other medications than Suboxone using his X number to SHY. Id. at 468. Respondent believed his care of SHY was within the standard of care. Id. 469-70.

JC2

Respondent treated JC2 for chronic pain, substance abuse, attention deficit disorder, and extreme anxiety. Tr. 458; GX 5C. Respondent acknowledged that JC2 was "a tough patient," who had been "fired" by other doctors and had abused Xanax. Tr. 458-60. A note in JC2's chart dated "9-1-09" indicates that a friend of JC2 had stated that he was taking twelve Xanax pills at a time. GX 5C, at 3.

Respondent noted in the chart that JC2 was abusing Xanax and "MUST STOP XANAX." Id. at 2, 12; see also Tr. 459-60, 628. In his testimony, Respondent stated that his treatment plan was to gradually taper JC2 off Xanax, which could take up to a year, or to manage JC2's intake. Tr. 460-62, 630. The chart also notes that in November 2009, JC2 missed two appointments and

was jailed for distribution. GX 5C, at 8. The chart also again notes "Reported taking [greater than] #12 Xanax @ a time." Id. Respondent also testified that he knew "for a fact in this young man's history [that] he has been jailed before" for "doing things [that were] inappropriate." Tr. 631.

The ALJ found that Respondent credibly testified that he could not just cease prescribing Xanax to JC2 because he could have seizures. Id. at 460-61. However, the patient file shows that notwithstanding Respondent's testimony that he planned to taper JC2 off of Xanax, he actually increased the daily doses of the prescriptions. Compare GX 5C, at 11 (Aug. 30, 2009 RX for 30 tablets of Xanax 1.0 mg, ½ BID (for daily dose of 1 mg)), with id. at 10 (Oct. 25, 2009 RX for 90 tablet of Xanax 1.0 mg., 1 TID (for daily dose of 3 mg)), with id. at 5 (Apr. 17, 2010 RX for 60 tablets of Xanax 2.0 mg, 1q12, with 2 refills (for daily dose of 4 mg)). The chart also demonstrates that Respondent wrote multiple Xanax and Suboxone prescriptions under his X number prior to February 28, 2010. GX 5C, at 7, 9-11, 13. Respondent testified that he conducted drug screens on JC2, but the results of these tests were not in JC2's medical record. Tr. 633-34.

Respondent testified that he prescribed Suboxone to treat JC2's substance abuse and that substance abuse was JC2's primary diagnosis. Id. at 643, 645. Moreover, a note for a visit of April 5, 2009, states "Desires To Get OFF Narcotics." GX 5C, at 15. Respondent also testified that JC2 was being seen for chronic pain caused by a football injury when he was a teenager, but he then admitted that JC2's chart does not document the source or severity of that pain. Tr. 654-55. Nor did Respondent document the history of the pain, any prior treatments for it and its effect on JC2's functioning. See GX 5C. Respondent maintained, however, that he knew JC2's history and "that he's had a lot of problems." Tr. 655.

Respondent also testified that JC2 had been in a narcotic treatment program in 2007 or 2008 and had left against medical advice. Id. at 631-632. Yet Respondent did not document this in JC2's chart and did not obtain his treatment records from the narcotic treatment facility. GX 5C. Respondent believed he treated JC2 within the standard of care. Tr. 461.

DA

DA saw Respondent three times: in December 2009, and in January and February of 2010. GX 5K. According to the progress note for the first visit, Respondent diagnosed DA with chronic pain and anxiety. Id. at 3. Respondent circled "YES" for whether DA had pain and noted that the location was his back and both legs. Id. Respondent did not, however, document the nature and intensity of the pain, its history, whether any treatments had been previously tried, and the pain's effect on his psychological and physical function at either this visit or his next visit. Id. at 3. Moreover, the progress notes for DA's first two visits (there is no note for a third visit on Feb. 21, 2010, even though there is a prescription for this date), indicate that Respondent performed a physical examination and found all areas normal. Id. Respondent did not document DA's vital signs for either visit. Id. Respondent also noted a diagnosis of substance abuse at DA's second visit but did not document the basis for this diagnosis. Id. Respondent issued DA prescriptions for both Suboxone and Xanax at all three visits, including on the second visit when he noted that DA had "NO" pain; on each occasion, Respondent issued the prescriptions under his X number. Id. at 4-5.

On June 1, 2010, the lead DI interviewed DA by phone. Tr. 85. DA told the DI that he was addicted to pain killers and that Respondent was treating him for this condition and not for chronic pain. Id. at 85-87. In his testimony, Respondent admitted that he did not get DA's medical records for his pain condition but maintained that he was familiar with this patient from

treating him in the emergency department of the Red Bay Hospital. Tr. 693; see generally GX 5K. Respondent believed that his care was appropriate for DA. Tr. 482.

AH

Respondent saw AH four times beginning on December 13, 2009, and ending on March 28, 2010. GX 5S. Respondent noted that AH was taking 12 Lortab 10 mg a day, which she was getting "from doctors, friends, [and] off the street." Tr. 493. Respondent diagnosed AH with both substance abuse and chronic pain as a secondary diagnosis. GX 5S, at 3. While Respondent noted "YES" for whether AH had pain, he did not document the nature, intensity and location of the pain; the history of the pain; what treatments had been used; and the pain's effect on her physical and psychological functioning. Id. at 3. Respondent also noted that AH was undergoing withdrawal, was agitated/moody, had insomnia and a positive MDQ. Id. AH's physical exam was normal and Respondent did not document having taken her vital signs. Id. At this visit, Respondent prescribed Suboxone to her under his X number. GX 5S, at 4.

At AH's second visit (Feb. 1), Respondent noted that she had "NO" pain and did not make any other findings about her pain; he also indicated that she did not demonstrate withdrawal, that she was not agitated or moody and did not have insomnia or a positive MDQ. GX 5S, at 7. Respondent did not note any abnormalities in the physical exam and did not document having taken AH's vital signs. Id. Respondent noted his diagnosis as Suboxone 16 mg. and gave AH a prescription for Suboxone which he wrote under his X number. Id. at 8.

On Feb. 28, Respondent issued AH a third prescription for Suboxone, again using his X number. Id. at 8. The progress note for this visit, however, lists AH's name, date of birth and a visit date but contains no medical information. Id. at 7.

On March 28, AH again saw Respondent. Id. at 5. At this visit, Respondent circled "YES" for whether she had pain and noted its location as her neck and back. Id. Once again, he did not document the nature and intensity of the pain, the history of the pain, what treatments had been used, and the pain's effect on her physical and psychological functioning. Id. Again, Respondent performed a physical exam but found no abnormalities; he also did not document having taken AH's vital signs. Id. Respondent made diagnoses of both chronic pain and substance abuse. Id. Respondent issued AH a new prescription for Suboxone, which was written on a prescription form that contained both of his numbers. Id. at 6.

Respondent testified that AH had some neck and back pain, but "appeared to be functional." Tr. 493. He was also "not convinced that [he] could not add the substance abuse potential to her." Id. Respondent stated that his treatment of AH was within the standard of care. Id. at 494.

NK

NK saw Respondent three times during February and March 2010. GX 5U. On the intake form, NK listed his medications as Suboxone and Xanax. Id. at 2. On the progress note for NK's first visit, Respondent noted that he had "NO" pain and did not indicate a location for any pain. Id. at 3. Respondent noted that he had performed a physical examination, but found no abnormalities; Respondent also did not document having taken NK's vital signs. Id. Respondent nonetheless diagnosed NK as having both chronic pain and anxiety (but not substance abuse) and gave him prescriptions for Suboxone and Xanax, both of which were written under his X number. Id. at 5.

On March 9, Respondent issued NK a second prescription for Suboxone, and on March 21, he issued NK prescriptions for both Suboxone and Xanax. Id. at 4-5. However, the progress

note dated Mar. 9 contains no medical information and there is no note for Mar. 21. See generally GX 5U.

On May 25, 2010, the lead DI interviewed NK. Tr. 78. NK stated that Respondent was treating him for opiate addiction, and not for any other medical problem including chronic pain. Id. at 79. NK also told the DI that he was no longer seeing Respondent and that "he would kick the habit himself." Id. at 78. NK's chart also contains a prescription for Suboxone dated April 17, 2010, even though NK did not see Respondent on that date. GX 5U, at 6. Respondent explained that he had prepared the prescription in advance of NK's visit, but that "no one gets that prescription unless I hand it to them." Tr. 497.

Respondent's Post-Suspension Conduct

On September 27, 2010, Respondent was personally served with the Order to Show Cause and Immediate Suspension of Registration. At that time, the lead DI explained to Respondent that, as of that date, he was no longer authorized to prescribe or handle any controlled substances. Tr. 112-13. Respondent told the DI that "he was not going to abide by this order and that (the DI) didn't have the authority to tell him that he couldn't prescribe any controlled substances." Id. at 113.

Thereafter, the lead DI discovered that Respondent had issued controlled-substance prescriptions which were dated September 29, October 3 and October 4, 2010. Tr. 114; GX 6. While the ALJ found that there were a total of four post-suspension prescriptions, two of the prescription forms contained prescriptions for two controlled substances. ALJ at 34; but see GX 6, at 3-4.

The first prescription, which was issued to CW and dated September 29, 2010, was for the drug Adderall, a schedule II controlled substance. GX 6, at 1. CW told the lead DI that

Respondent wrote the prescription after she had been seen by Respondent's Physician's Assistant, CC. CW picked up the prescription the next day, September 30. Tr. 115-118; GX 6, at 1. Respondent admitted to signing this prescription. Tr. 506-07; see also RX 29, at 17-19 (CW's chart for Sept. 29, 2010 visit).

The second prescription, which was issued to JB and dated October 3, 2010, was also for Adderall. Tr. 118-19, 200-01; GX 6, at 2. However, the evidence showed that Respondent had issued the prescription on September 3, 2010. Tr. 119-20, 508, 733-34. This prescription did not, however, include Respondent's registration number and listed only his X number. GX 6, at 2.

The lead DI contacted the pharmacist who filled the prescription, and was told that the pharmacy would not accept a post-dated prescription for a scheduled drug. Tr. 123. The pharmacist remembered this prescription and further stated that it had actually been presented for filling on October 3, 2010. Tr. 123-24, 158-59. The lead DI testified that while it would have been permissible to write a prescription and sign it on September 3, 2010, with the annotation of "do not fill until October 3, 2010," it was not permissible for Respondent to sign a schedule II prescription on September 3 but date the prescription for October 3rd. Tr. 124.

The evidence also included two prescriptions issued (on a single prescription form) to MK and dated October 4, 2010; the prescriptions were for 60 Adderall and 90 Lortab 10 mg, another schedule III narcotic. GX 6, at 3. The lead DI contacted MK about the prescriptions; MK confirmed that the prescriptions were written and received on October 4, 2010. Tr. 124-25. While Respondent testified that the prescriptions had been post-dated, he admitted to having written the prescriptions on September 29, two days after he was served with the Immediate Suspension Order. Tr. 508-09; 740-41. Respondent maintained that the prescription was given

to MK by mistake. Id. at 741. MK's patient file includes a progress note which establishes that she saw Respondent on September 29, 2010. RX 32, at 28. Notwithstanding the testimony regarding MK's statement as to the date the prescriptions were written, I find that the prescriptions were written on September 29.

The evidence also included two prescriptions which were issued to DH and also dated October 4, 2010. GX 6, at 4. The prescriptions were for 90 Lortab 10 mg and 90 Xanax 1 mg. Tr. 126, 509; GX 6, at 4.

Respondent testified that he thought that he had seen DH in September but that he did not know "exactly which day I saw him." Tr. 509. Respondent admitted, however, that the prescription was in his handwriting and that he "signed it." Continuing, he maintained that he did not have an explanation for it, that "[t]his was an accident," and that he "would never do anything to violate an order." Id. at 509.

According to DH's patient file, DH saw Respondent on September 29, 2010.[14] RX 31, at 28. The chart for the visit noted that DH was "Here for med refills" and that he was "here for Dr. Cochran," and that his "Current Meds" were Lortab and Xanax. Id. In addition, Respondent signed the chart. Id. I therefore find that Respondent wrote the prescriptions on September 29.

Respondent's Testimony

Respondent maintained that some of the patients did not know what they were being treated for. Tr. 743-44. However, Respondent did not document any patient's lack of understanding of his diagnosis in the patient files. Tr. 745. Moreover, the ALJ did not find this testimony credible. ALJ at 49.

[14] DH's previous visit was on August 4, 2010. RX 31, at 30.

As noted above, Respondent provided evidence that he had stopped prescribing methadone to his patients. Moreover, Respondent established that he had stopped using his X number to write prescriptions for drugs other than Suboxone and when prescribing Suboxone to treat pain. However, on September 3, 2010, Respondent wrote a further controlled substance prescription for Adderall (which was post-dated) under his X number. GX 6, at 2.

Respondent also testified that he maintained the drugs screens he ordered on his patients in a separate file which he called the "Drug Screen Book." Tr. 687. Respondent testified that when the DIs obtained the patient files, they did not take the Drug Screen Book." Id. Respondent did not, however, submit the Drug Screen Book for the record.

Respondent agreed that his patient charts were incomplete. Tr. 452. In one case Respondent testified that his record keeping was incorrect and he had mistakenly written the wrong primary diagnosis for the patient. Id. at 654. Respondent, however, offered no evidence that he was prepared to comply with the Alabama Board's Guidelines For The Use Of Controlled Substances For The Treatment Of Pain. See Ala. Admin Code r.540-x-4-.08.

DISCUSSION

Section 304(a) of the Controlled Substances Act provides that a "registration pursuant to section 823 of this title to . . . dispense a controlled substance . . . may be suspended or revoked by the Attorney General upon a finding that the registrant . . . has committed such acts as would render his registration under section 823 of this title inconsistent with the public interest as determined under such section." 21 U.S.C. § 824(a)(4). In determining the public interest, Congress directed that the following factors be considered:

(1) The recommendation of the appropriate State licensing board or professional disciplinary authority.

(2) The applicant's experience in dispensing . . . controlled substances.

(3) The applicant's conviction record under Federal or State laws relating to the manufacture, distribution, or dispensing of controlled substances.

(4) Compliance with applicable State, Federal, or local laws relating to controlled substances.

(5) Such other conduct which may threaten the public health and safety.

21 U.S.C. § 823(f). In addition, pursuant to 21 U.S.C. § 824(d), "[t]he Attorney General may, in his discretion, suspend any registration simultaneously with the institution of proceedings under this section, in cases where he finds that there is an imminent danger to public health or safety."

The public interest factors are considered in the disjunctive. Robert A. Leslie, 68 FR 15227, 15230 (2003). I may rely on any one or a combination of factors and may give each factor the weight I deem appropriate in determining whether to revoke an existing registration or to deny an application for a registration. Id. Moreover, I am "not required to make findings as to all of the factors." Hoxie v. DEA, 419 F.3d 477, 482 (6th Cir. 2005); see also Morall v. DEA, 412 F.3d 165, 173-74 (D.C. Cir. 2005).

The Government has "the burden of proving that the requirements for . . . revocation or suspension pursuant to section 304(a) . . . are satisfied." 21 CFR 1301.44(e); see also 21 CFR 1301.44(d) (Government has "the burden of proving that the requirements for [a] registration pursuant to section 303 . . . are not satisfied"). However, where the Government satisfies its prima facie burden, the burden then shifts to the registrant to demonstrate why he can be entrusted with a new registration. Medicine Shoppe-Jonesborough, 73 FR 364, 380 (2008).

Having considered all of the factors, I conclude that the Government's evidence pertinent to factors two (Respondent's experience in dispensing controlled substances) and four

(Respondent's compliance with applicable laws related to controlled substances), establishes that Respondent has committed acts which render his registration "inconsistent with the public interest." 21 U.S.C. § 824(a)(4). I further conclude that Respondent has not rebutted the Government's prima facie case.

Factors One and Three – The Recommendation of the State Board and Respondent's Record of Convictions Under Laws Relating To The Manufacture, Distribution and Dispensing of Controlled Substances

The record establishes that the State Board has an open investigation of Respondent. However, the Board has not made a recommendation in this matter, and it is undisputed that Respondent's medical license remains active and unrestricted. Accordingly, this factor does not support a finding either for, or against, the continuation of Respondent's registration. See Joseph Gaudio, 74 FR 10083, 10090 n.25 (2009); Mortimer B. Levin, 55 FR 8209, 8210 (1990).

There is also no evidence in the record that Respondent has been convicted of an offense related to the manufacture, distribution or dispensing of controlled substances. While this factor supports the continuation of Respondent's registration, DEA has long held that this factor is not dispositive. See, e.g., Edmund Chein, 72 FR 6580, 6593 n.22 (2007).

Factors Two and Four – Respondent's Experience in Dispensing Controlled Substances and Compliance with Applicable Laws Related to Controlled Substances

The record establishes that Respondent violated numerous provisions of Federal law and DEA regulations. These include: 1) the prescribing of methadone for substance abuse treatment without being registered to do so under 21 U.S.C. § 823(g)(1), in violation of 21 U.S.C. § 841(a)(1); 2) the prescribing of methadone for substance abuse treatment, in violation of 21 CFR 1306.04(c) and 1306.07; 3) prescribing controlled substances without a legitimate medical purpose, in violation of 21 CFR 1306.04(a); 4) the post-dating of prescriptions, in violation of 21

CFR 1306.05(a); and 5) prescribing controlled substances when his registration had been suspended, in violation of 21 U.S.C. § 843(a)(2).

The Methadone Prescriptions

Under 21 U.S.C. § 823(g)(1), "practitioners who dispense narcotic drugs to individuals for maintenance treatment or detoxification treatment shall obtain annually a separate registration [from their practitioner's registration] for that purpose."[15] In the Drug Addiction Treatment Act of 2000, Congress provided that the requirement to obtain a separate registration is "waived in the case of the dispensing (including the prescribing), by a practitioner, of narcotic drugs in schedule III, IV, or V or combinations of such drugs if the practitioner meets the conditions specified in [section 823(g)(2)(B)] and the narcotic drugs or combinations of such drugs meet the conditions specified in [section 823(g)(2)(C)]." Id. § 823(g)(2)(A) (emphasis added).

Methadone is, however, a schedule II narcotic, and thus, except for where a patient presents with acute withdrawal symptoms (and then for no more than a total of three days), cannot be lawfully dispensed for the purpose of maintenance or detoxification treatment absent the practitioner's holding a registration under section 823(g)(1). See 21 U.S.C. § 812(c) (Schedule II (b)(11)); 21 CFR 1308.12(c)(15). Moreover, under DEA's regulations, "[a] prescription may not be issued for 'detoxification treatment' or 'maintenance treatment,' unless the prescription is for a Schedule III, IV, or V narcotic drug approved by the Food and Drug

[15] An applicant for registration under this provision must meet three requirements: 1) the applicant must be "determined by the Secretary [of HHS] to be qualified . . . to engage in the treatment with respect to which registration is sought; 2) the Attorney General must "determine[] that the applicant will comply with standards . . respecting (i) security of stocks of narcotic drugs for such treatment, and (ii) the maintenance of records . . on such drugs," and 3) "if the Secretary determines that the applicant will comply with standards . . . respecting the quantities of narcotic drugs which may be provided for unsupervised use by individuals in such treatment." 21 U.S.C. § 823(g)(1).

Administration specifically for use in maintenance or detoxification treatment." 21 CFR 1306.04(c).[16] See also id. 1306.07(a) ("A practitioner may administer or dispense directly (but not prescribe) a narcotic drug listed in any schedule . . . for the purpose of maintenance or detoxification treatment if the practitioner . . . is separately registered with DEA as a narcotic treatment program [and] is in compliance with DEA regulations regarding treatment qualifications, security, records, and unsupervised use of the drugs pursuant to the [CSA].") (emphasis added); id. 1306.07(b) ("Nothing in this section shall prohibit a physician . . . from administering (but not prescribing) narcotic drugs to a person for the purpose of relieving acute withdrawal symptoms when necessary while arrangements are being made for referral for treatment. Not more than one day's medication may be administered to the person or for the person's use at one time. Such emergency treatment may be carried out for not more than three days and may not be renewed or extended.") (emphasis added).

Also relevant here is the definition of the term "maintenance treatment." 21 U.S.C. § 802(29). Under the CSA, the term "means the dispensing, for a period in excess of twenty-one days, of a narcotic drug in the treatment of an individual for dependence upon heroin or other morphine-like drugs." Id.[17]

Finally, Respondent claimed that most of the patients whose files were introduced into evidence (including some of the methadone patients) were chronic pain patients. Under a

[16] See also 21 CFR 1306.07(d) ("A practitioner may administer or dispense (including prescribe) any Schedule III, IV, or V narcotic drug approved specifically by the Food and Drug Administration specifically for use in maintenance or detoxification treatment to a drug dependent person if the practitioner complies with the requirements of [21 CFR 1301.28]." 21 CFR 1301.28 is the provision which implements the DATA Waiver Act.

[17] The CSA also defines the term "detoxification treatment." 21 U.S.C. § 802(30). The term "means the dispensing, for a period not in excess of one hundred and eighty days, of a narcotic drug in decreasing doses to an individual in order to alleviate adverse physiological or psychological effects incident to withdrawal from the continuous or sustained use of a narcotic drug and as a method of bringing the individual to a narcotic drug-free state within such period." Id.

longstanding DEA regulation, to be effective, "[a] prescription for a controlled substance . . . must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice." 21 CFR 1306.04(a). As the Supreme Court has explained, "the prescription requirement . . . ensures patients use controlled substances under the supervision of a doctor so as to prevent addiction and recreational abuse. As a corollary, [it] also bars doctors from peddling to patients who crave the drugs for those prohibited uses." Gonzales v. Oregon, 546 U.S. 243, 274 (2006) (citing United States v. Moore, 423 U.S. 122, 135, 143 (1975)).

Under the CSA, it is fundamental that a practitioner must establish and maintain a bonafide doctor-patient relationship in order to act "in the usual course of . . . professional practice" and to issue a prescription for a "legitimate medical purpose." Laurence T. McKinney, 73 FR 43260, 43265 n.22 (2008); see also Moore, 423 U.S. at 142-43 (noting that evidence established that physician "exceeded the bounds of 'professional practice,'" when "he gave inadequate physical examinations or none at all," "ignored the results of the tests he did make," and "took no precautions against . . . misuse and diversion"). The CSA, however, generally looks to state law to determine whether a doctor and patient have established a bonafide doctor-patient relationship. See Kamir Garces-Mejias, 72 FR 54931, 54935 (2007); United Prescription Services, Inc., 72 FR 50397, 50407 (2007).

By regulation, the Alabama Board of Medical Examiners has adopted Guidelines For The Use of Controlled Substances For The Treatment of Pain. See Ala. Admin. Code r. 540-X-4-.08. According to the Board, the "guidelines are not intended to define complete or best practice, but rather to communicate what the Board considers to be within the boundaries of professional practice." Id. (1)(g). Guideline (2)(a), which is captioned "Evaluation of the Patient," states:

> A complete medical history and physical examination must be conducted and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

Id. (2)(a).[18]

The record contains substantial evidence that Respondent prescribed methadone to opiate addicted patients for the purpose of providing maintenance treatment. During his initial interview (on Feb. 28, 2010) with the Investigators, Respondent told them that "he was operating a detox clinic where he was using methadone to get his patients onto Suboxone." Tr. 43. It was not until later that day, when the Investigators interviewed Respondent for the second time, that he claimed that he prescribed methadone for pain and that he had previously misspoken. Id. at 55.

---

[18] See also Ala. Admin. Code r. 540-X-4.08(2)(b) ("The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned.").

The Guidelines also provide that:

> The physician should keep accurate and complete records to include
>
> 1. the medical history and physical examination;
> 2. diagnostic, therapeutic and laboratory results;
> 3. evaluations and consultations;
> 4. treatment objectives;
> 5. discussion of risks and benefits;
> 6. treatments;
> 7. medications (including date, type, dosage and quantity prescribed);
> 8. instructions and agreements;
> 9. periodic reviews.

Id. 2(f).

Other evidence supports the conclusion that Respondent was prescribing methadone to provide maintenance or detoxification treatment to opiate addicted patients. On the date of the visit, Investigators interviewed JKB, who told them that he was being treated by Respondent with methadone for opiate addiction. Id. at 52. JKB further stated that he had previously gone to a narcotic treatment program, which used methadone, and that he was seeing Respondent because the latter charged less. Id. at 52-53. JKB also stated that Respondent was not treating him for chronic pain. Id. at 53.

The Government introduced into evidence seven files of patients who received methadone prescriptions from Respondent. GXs 5X; 5O; 5A; 5N; 5L; 5M; and 5T. The Government also elicited the testimony of the DIs to the effect that they had interviewed several of the patients to determine what condition they were being treated for.

Patient TP related that she had gone to Respondent because she had heard that he was using methadone to treat addiction; TP also noted on her intake form that she had previously gone to a methadone clinic and was taking twelve tablets of methadone 10 mg strength a day. Respondent issued her prescriptions for methadone on three separate dates over the course of a month, and ultimately TP returned to a methadone clinic.

While Respondent maintained that TP had been going to the methadone clinic for pain, he conceded that the purpose of a methadone clinic is to treat addiction. Moreover, while Respondent noted diagnoses of both chronic pain and substance abuse on TP's progress notes, he did not document having taken a medical history, the nature and intensity of any pain, current and past treatments for paint, and its effect on her physical and psychological functioning.

I thus conclude that Respondent prescribed methadone to TP for maintenance or detoxification purposes and not to treat chronic pain. In doing so, he violated the CSA because

he did not have the registration required under section 823(g)(1) to dispense methadone for this purpose; he also violated DEA regulations which prohibit the prescribing of narcotic drugs for this purpose except for those drugs in schedules III through V which have been specifically approved by the FDA to provide maintenance or detoxification treatment. 21 CFR 1306.04(c).

The DIs also interviewed MB, who stated that she was being treated by Respondent for an addiction to Lorcet and not for chronic pain. Respondent testified, however, that he was treating MB both for chronic pain cause by headaches and substance abuse. Respondent prescribed methadone to her on six different dates.

Notably, the Government did not produce any evidence corroborating MB's statement that she was not being treated for chronic pain. See Consolidated Edison Co. v. NLRB, 305 U.S. 197, 230 (1938) ("Mere uncorroborated hearsay . . . does not constitute substantial evidence.). However, even if this evidence is not sufficient to establish that Respondent was treating her only for substance abuse and crediting his testimony that he was also treating her for chronic pain, I conclude that the prescriptions were unlawful.

Notably, Respondent did not document the nature and intensity of her pain, its effect on both her physical and psychological function, any prior or current treatment for it, and her history of substance abuse. See Ala. Admin Code r.540-X-4.08(2)(a). Accordingly, because Respondent did not make any of the findings required under the Alabama guidelines, I conclude that he did not have a basis for his diagnosis of chronic pain. I thus conclude that Respondent acted outside of "the usual course of . . . professional practice" and lacked a "legitimate medical

purpose" in issuing the methadone prescriptions to MB and violated Federal law. 21 CFR 1306.04(a).[19]

Respondent issued three methadone prescriptions (on Feb. 9, 23, and Mar. 9) to JC1 (GX 5N), each of which was for 210 tablets with a daily dose of 150 mg. Respondent admitted that JC1 had come from another methadone clinic even though he denied that JC1 had gone to the clinic to be treated for addiction and maintained that he had gone there for pain management. Moreover, while Respondent also maintained that JC1 had come to him because "he wanted to take a cleaner medicine for his pain," when Respondent stopped writing methadone prescriptions, JC1 decided to go to another treatment facility.

In addition, notwithstanding Respondent's claim that he was treating JC1 for pain, at his first two visits (and at which Respondent prescribed methadone), Respondent noted that JC1 had "NO" pain; and at the third visit, where he issued a further methadone prescription, Respondent did not even make a progress note. Respondent also failed to document any of the findings set forth in Alabama's Guideline 2(a). Accordingly, I conclude that Respondent prescribed methadone to JC1 for maintenance/detoxification purposes without the required registration and violated DEA regulations which prohibit the prescribing of schedule II narcotics for this purpose. 21 U.S.C. §823(g)(1); 21 CFR 1306.04(c).

JB also came to Respondent from a narcotic treatment program, which he had been kicked out of. Respondent noted this in the chart and that JB "desire[d] to get off methadone." Respondent asserted that the fact that JB had been treated at a methadone clinic did not mean that the clinic was treating him for addiction, even though that is the purpose of a methadone

[19] As explained above, if Respondent was treating MB for substance abuse, the methadone prescriptions were illegal because methadone cannot be prescribed for this purpose and because he did not hold the required registration. See 21 U.S.C. § 823(g)(1); 21 CFR 1306.07(a) & (b).

clinic; moreover, he admitted that he did not obtain JB's records from the clinic. After Respondent stopped prescribing methadone to JB, the latter went to another methadone clinic.

While Respondent documented that JB had foot and knee pain, and the progress notes include a few additional statements regarding his pain such as the location and that JB had been in an accident, the notes do not document the nature and intensity of pain, any prior treatments for it, and its effect on JB's functioning. Moreover, Respondent noted that he planned to put JB on his alternative medication program. Given JB's prior history of substance abuse treatment and his express "desire to get off methadone," I conclude that Respondent's primary purpose in prescribing methadone to him (which he did on three occasions over a month) was to provide maintenance/detoxification treatment. I thus conclude that Respondent violated the CSA and DEA regulations in doing so. 21 U.S.C. § 823(g)(1); 21 CFR 1306.04(c).

Respondent testified that NB told him at the initial visit that she had been on 180 mg of methadone which she was taking for pain. He also testified that she was a "troubling patient" because she was on both methadone and Xanax and that this was a great concern, especially if she mixed the drugs with alcohol. Respondent diagnosed NB as having chronic pain even though he noted on her chart that she had "NO" pain, and he did not document any further findings to support a diagnosis of chronic pain. Moreover, notwithstanding his express concern that NB was on both methadone and Xanax, Respondent prescribed Xanax to her and did not document that she had anxiety, although he maintained in his testimony that she "had some anxiety."

The evidence is insufficient to support the conclusion that NB sought treatment from Respondent for a substance abuse problem. However, the evidence does support the conclusion that Respondent acted outside of the usual course of professional practice and lacked a legitimate

medical purpose in prescribing methadone to her. 21 CFR 1306.04(a). Having noted on NB's chart that she had "NO" pain, and having failed to document any further findings as required by the Guidelines to support his chronic pain diagnosis (and to explain the inconsistency between his diagnosis and his notation that she had no pain), it is clear that Respondent lacked a legitimate medical purpose in prescribing methadone to her.

KI noted on her intake form that she was using three controlled substances: methadone, Xanax and Ambien. Respondent also acknowledged that KI had previously been treated at a narcotic treatment facility and that she had taken narcotics and become addicted to them. However, he denied that KI had told her that she had gone to the methadone clinic to treat her addiction – as if there was any other reason a person would seek treatment from a methadone clinic. While Respondent maintained that KI had diagnoses of both substance abuse and chronic pain, on the progress note for her initial visit, he noted that she had "NO" pain although he wrote "Back" as the location. Respondent did not document any findings that would explain the inconsistency between his diagnosis and his having noted that KI had "NO" pain; he also did not document the history of any pain, what treatment had been used, and the pain's effect on her physical and psychological functioning.

Respondent issued three methadone prescriptions to KI. I conclude that Respondent's purpose in doing so was not to treat pain, but to provide maintenance/detoxification treatment to her. I thus conclude that Respondent violated Federal law by prescribing methadone to KI for maintenance/detoxification treatment without the required registration and violated DEA

regulations which prohibit the prescribing of schedule II narcotics for this purpose. 21 U.S.C. § 823(g)(1); 21 CFR 1306.04(c).[20]

The Suboxone Prescriptions

As found above, Respondent also prescribed Suboxone, a schedule III controlled substance, to numerous patients. The Government elicited the testimony of the DIs as to phone interviews they conducted with sixteen of these patients, the majority of whom said that Respondent was treating them for substance abuse and not chronic pain. See Tr. at 78 (NK); id. at 80-81 (AG); id. at 82-83 (LM); id. at 83-84 (ET); id. at 85-87 (DA); id. at 87-88 (CT); id. at 89-90 (JH); id. at 92-94 (KP); id. at 95-98 (SS); id. at 266-67 (CML); id. at 268-69 (SJW); id. at 270 (LMJ); id. at 271 (MR); id. at 288-89 (SHY).

As found above, Respondent testified that many of these patients were actually being treated for chronic pain in addition to substance abuse, or were just being treated for chronic pain. Moreover, Respondent frequently noted both diagnoses on the patient's charts, although in some instances he did not note a substance abuse diagnosis until after the first visit (and sometimes not until after several visits). See, e.g., GX 5P (AG); GX 5V (LM); GX 5Y (CT); GX 5R (JH); GX 5B (TB); GX 5J (SW); GX 5I (SJW); GX 5E (LMJ); GX 5D (SHY); GX 5K (DA).

However, even if it is the case that most of the Suboxone patients were being treated only for substance abuse, the Government did not offer any evidence (whether in the form of clinical standards or expert testimony) establishing what the appropriate course of professional practice requires of a physician treating patients for substance abuse.[21] In short, while in its brief, the Government repeatedly argues that Respondent lacked a medical justification to support his

[20] Given the conflicting evidence regarding DG, I decline to make any legal conclusions regarding Respondent's prescribing of methadone to him.

[21] While the Government introduced the Alabama Guidelines on using controlled substances to treat pain, it offered no evidence establishing that these standards apply to the treatment of substance abuse patients.

diagnosis of substance abuse for the various patients and his issuance of the Suboxone prescriptions, the Government's failure to offer any probative evidence as to the standards of medical practice for diagnosing and treating a substance abuse patient precludes a finding that Respondent lacked a legitimate medical purpose when he prescribed Suboxone to these patients.

Respondent, however, testified that many of the Suboxone patients were actually being treated for chronic pain, and he noted this as his primary diagnosis in many of their charts. As explained above, the Alabama Guidelines require that a physician who prescribes controlled substances to treat pain, obtain "[a] complete medical history" and document this in the patient's medical record. Moreover, the Guidelines state that the record "should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse." Ala. Admin. Code r. 540-X-4-.08(2)(A).

As found above, at the initial visits of nine of the Suboxone patients, Respondent diagnosed them as having chronic pain but not substance abuse. See supra Findings for Patients SS, ET, KP, CL, CML, MR, SHY, DA, and NK. Notwithstanding his diagnosis, Respondent typically did not even list a location of a patient's purported pain and/or did not list a location until after the patient had made several visits. See supra Findings for ET, KP, CL, CML, SHY, NK. Moreover, Respondent did not document the nature and intensity of the patient's pain, the pain's effect on the patient's ability to function, and rarely documented any past treatments for the pain, and the patient's substance abuse history at either the initial visit or follow-up visits.[22]

[22] While Respondent's charts included a Plan section, none of them included the "objectives that will be used to determine treatment success." Ala. Admin. Code r.540-X-4-.08(2)(b).

Tellingly, in the charts, Respondent frequently noted that the patients had "NO" pain, yet nonetheless diagnosed them as having chronic pain. See Findings for SS, ET, KP, CL, MR, SHY, and NK. Respondent offered no explanation for the inconsistency between his findings and his diagnosis with respect to any of these patients. Based on Respondent's having noted that these patients had no pain and his failure to offer any explanation for why he nonetheless diagnosed the patients as having chronic pain, I conclude that Respondent lacked a legitimate medical purpose and acted outside of the usual course of professional practice in violation of 21 CFR 1306.04(a) when he prescribed Suboxone to these patients for the purpose of treating chronic pain.

The Government further argues, and the ALJ agreed, that Respondent violated 21 CFR 1306.07(c), because his "charts failed to show the use of any treatment options besides the prescribing of controlled substances." ALJ at 47. The ALJ further explained that "[s]uch lack of attempts of alternative modalities prior to determining that the patient suffers from chronic pain violates" this regulation. Id.

Both the Government and the ALJ clearly misread the regulation. This provision, which is part of the regulation setting forth the requirements for dispensing narcotic controlled substances "to a narcotic dependant[sic] person for the purpose of maintenance or detoxification treatment" states:

> This section is not intended to impose any limitations on a physician or authorized hospital staff to administer or dispense narcotic drugs in a hospital to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of conditions other than addiction, or to administer or dispense narcotic drugs to persons with intractable pain in which no relief or cure is possible or none had been found after reasonable efforts.

21 CFR 1306.07(c).

The Government's and the ALJ's construction of this regulation as imposing – by implication no less - an affirmative obligation for a physician to engage in alternative treatment modalities cannot be squared with the purpose of the CSA, which "manifests no intent to regulate the practice of medicine generally," an authority which remains vested in the States. Gonzales v. Oregon, 546 U.S. 243, 270 (2006). Rather, in any case, whether a physician has an adequate basis for concluding that "no relief or cure is possible" for a patient's pain, or that alternative treatments should be tried, is a clinical judgment which must be assessed by reference to the standards of medical practice as set by the state medical boards and the profession itself. While a practitioner's failure to recommend alternative treatments may provide some evidence as to whether a prescription complies with 21 CFR 1306.04(a), the Government produced no expert testimony establishing with respect to any patient, that under the standards of medical practice, Respondent was required to recommend alternative treatments.[23]

Other Allegations

The ALJ found that "[t]he parties do not dispute that Respondent improperly used his 'X' prescription registration to prescribe controlled and non-controlled substances other than Suboxone or Subutex." ALJ at 43. The problem with the ALJ's reasoning is that an X number is not a registration at all, but only an identification number.

As the statute states: "Upon receiving a notification under subparagraph (B) [of a practitioner's intent to prescribe narcotic drugs in schedules III through V for maintenance or detoxification treatment], the Attorney General shall assign the practitioner involved an

[23] The ALJ noted that "Respondent testified, and the record contains no expert evidence to the contrary, that his treatment of his patients met the standard of care." ALJ at 48. While evidence as to the standard of care is admissible in criminal prosecutions under 21 U.S.C. § 841(a)(1), I conclude that the Alabama Guidelines provide substantial evidence as to accepted boundaries of professional practice in prescribing controlled substances for the treatment of pain. See Ala. Admin. Code r. 540-X-4-.08(1)(g) (guidelines are intended "to communicate what the Boards considers to be within the boundaries of professional practice").

identification number under this paragraph for inclusion with the registration issued for the practitioner pursuant to subsection (f) of this section." 21 U.S.C. § 823(g)(2)(D)(ii) (emphasis added). See also 21 CFR 1301.28(a) ("An individual practitioner may dispense or prescribe Schedule III, IV, or V narcotic controlled drugs . . . which have been approved by the Food and Drug Administration (FDA) specifically for use in maintenance or detoxification treatment without obtaining the separate registration required by § 1301.13(e). . . ."); id. § 1301.28(d)(1) ("If the individual practitioner has the appropriate registration under § 1301.13, then the Administrator will issue the practitioner an identification number . . . .") (emphasis added).

Moreover, under DEA's regulations,

> [a]ll prescriptions for controlled substances shall be dated as of, and signed on, the day when issued and shall bear the full name and address of the patient, the drug name, strength, dosage form, quantity prescribed, directions for use and the name, address and registration number of the practitioner. In addition, a prescription for a Schedule III, IV, or V narcotic drug approved by FDA specifically for 'detoxification treatment' or 'maintenance treatment' must include the identification number issued by the Administrator under § 1301.28(d) of this chapter or a written notice stating that the practitioner is acting under the good faith exception of § 1301.28(e).

21 CFR 1306.05(a). See also 21 CFR 1301.28(d)(3) ("The individual practitioner must include the identification number on all records when dispensing and on all prescriptions when prescribing narcotic drugs under this section.").

As found above, Respondent issued numerous controlled substance prescriptions (for both Suboxone and other drugs) on forms that listed only his X number. The Suboxone prescriptions issued in this manner violated DEA's regulation because Respondent was required to include both his X number and his practitioner's registration number on them. See 21 CFR 1306.05(a). Moreover, because he did not include his practitioner's registration number, the non-Suboxone controlled substance prescriptions violated this provision as well.

The ALJ also concluded that "Respondent improperly prescribe Suboxone for substance abuse using his regular DEA registration number rather than the required X number." ALJ at 43. Apparently, this was because Respondent eventually started listing both numbers on his prescription blanks. However, as set forth above, DEA's regulation expressly requires that a practitioner include both his registration number and his X number when issuing a prescription for Suboxone for maintenance or detoxification treatment under the authority of 21 CFR 1301.28. See 21 CFR 1306.05(a).

Moreover, while a "practitioner must include the identification number . . . on all prescriptions when prescribing narcotic drugs" for the purpose of providing maintenance or detoxification treatment, id. 1301.28(d), nothing in DEA regulations prohibits a practitioner from including both his practitioner's registration number and his X identification number on his prescription blanks. Nor does any DEA regulation require that a practitioner cross-out his X number when writing a prescription for controlled substances other than Suboxone (or Subutex) on a prescription blank that includes both numbers.

The evidence also shows that Respondent violated the Immediate Suspension Order by issuing multiple prescriptions after he was served with the Order. Under 21 U.S.C. § 843(a)(2), it is "unlawful for any person knowingly or intentionally . . . to use in the course of the distribution[] or dispensing of a controlled substance, a registration number which is . . . suspended[.]"

The evidence clearly shows that Respondent was personally served with the Immediate Suspension Order on September 27, 2010, at which time he told the Investigator that "he was not going to abide by this order and that [the DI] didn't have the authority to tell him that he couldn't prescribe any controlled substances." Tr. 113. True to his word, two days later, however, he

issued prescriptions to CW for Adderall, to MK for Adderall and Lortab, and to DH for Lortab and Xanax. Respondent's explanation that these prescriptions were just mistakes or accidents is totally unpersuasive.

The prescriptions to MK and DH, as well as a further Adderall prescription which was issued to JB, were unlawful for the further reason that they were post-dated. As set forth above, under 21 CFR 1306.05(a), "[a]ll prescriptions for controlled substances shall be dated as of, and signed on, the day when issued." Respondent admitted that on September 3, 2010, he issued CW a prescription for Adderall, a schedule II controlled substance which he dated October 3, 2010. Moreover, both Respondent's testimony and documentary evidence establish that Respondent wrote the prescription to MK and DH on September 29, while post-dating them to October 4. Accordingly, I also find that Respondent violated DEA regulations in writing these prescriptions.

I further find that Respondent lacked a legitimate medical purpose in prescribing Xanax to JC2. The evidence shows that Respondent knew that JC2 was abusing Xanax and that he had been jailed for distribution. While Respondent testified that he could not simply stop prescribing the drug to JC2 because JC2 could have seizures, and that he planned to taper JC2 off the drug, Respondent actually increased the daily dose of JC2's Xanax prescriptions. Given the inconsistency between the medical justification Respondent offered for his continuing to prescribe Xanax to JC2 and the actual prescriptions he issued, I conclude that Respondent lacked a legitimate medical purpose and acted outside the usual course of professional practice in prescribing Xanax to JC2. 21 CFR 1306.04(a).

The record thus establishes that Respondent's experience in dispensing controlled substances (factor two) and his record of compliance with applicable laws related to controlled

substances (factor four) is characterized by his multiple violations of Federal law. These include his prescribing of methadone for maintenance or detoxification purposes without being registered to do so and in violation of DEA regulations prohibiting the prescribing of methadone for this purpose; his prescribing of controlled substances to treat chronic pain without a legitimate medical purpose; his prescribing of Xanax to JC2; his issuance of prescriptions which lacked his practitioner's registration number; his issuance of post-dated prescriptions; and his issuance of multiple prescriptions after his registration had been suspended. I further conclude that the Government has made a prima facie showing that Respondent has committed acts which render his registration "inconsistent with the public interest," 21 U.S.C. § 824(a)(4), and that this conduct is sufficiently egregious to warrant the revocation of his registration.[24]

SANCTION

Under Agency precedent, where, as here, the Government has made out a prima facie case that a registrant has committed acts which render his "registration inconsistent with the public interest," he must "'present[] sufficient mitigating evidence to assure the Administrator that [he] can be entrusted with the responsibility carried by such a registration.'" Samuel S. Jackson, 72 FR 23848, 23853 (2007) (quoting Leo R. Miller, 53 FR 21931, 21932 (1988)).

[24] With respect to factor five, the ALJ found that Respondent's "lack of candor . . . threatens public health and safety." ALJ at 49. As support for this conclusion, the ALJ noted that most of the patients who were interviewed by the Investigators had stated that Respondent was treating them for substance abuse, yet Respondent testified that they were being treated for chronic pain but did not realize this. Id.

While I agree with the ALJ that Respondent lacked candor, and appreciate that she personally observed his testimony, I do so based on different evidence. First, during the initial interview on Feb. 28, 2010, Respondent told the investigators that he was operating a detox clinic and was using methadone to transfer his patients to Suboxone. Tr. 43. Yet later that day, he claimed that he was prescribing methadone only for pain and had previously misspoken. Id. at 54-55. Second, when confronted with evidence that several of his methadone patients had come to him from methadone clinics, he attempted to justify his unlawful prescribing of methadone to them by claiming that the patients had actually gone to these clinics to treat their pain. See Tr. 695-96 (testimony regarding JB); id. at 699 (testimony regarding JC); id. at 716-17 (testimony regarding KI); id. at 728 (testimony regarding TP). This factor thus also supports revocation.

"Moreover, because 'past performance is the best predictor of future performance,' ALRA Labs., Inc. v. DEA, 54 F.3d 450, 452 (7th Cir. 1995), this Agency has repeatedly held that where a registrant has committed acts inconsistent with the public interest, the registrant must accept responsibility for [his] actions and demonstrate that [he] will not engage in future misconduct." Medicine Shoppe-Jonesborough, 73 FR 364 (2008). As the Sixth Circuit has recognized, this Agency also "properly consider[s]" a registrant's admission of fault and his candor during the investigation and hearing to be "important factors" in the public interest determination. See Hoxie, 419 F.3d at 483.

The ALJ found, and the record supports the conclusion, that Respondent eventually ceased prescribing methadone for maintenance and detoxification purposes. ALJ at 49-50. The record generally supports the conclusion that Respondent stopped writing controlled substance prescriptions which did not include his registration number, as required by DEA regulations. However, as found above, in September 2010, Respondent issued a further Adderall prescription to JB and did not include his registration number.

The ALJ further noted that Respondent expressed remorse for some of his wrongdoing. ALJ at 50. However, while Respondent maintained that he had mistakenly issued the post-suspension prescriptions, and "would never do anything to violate an order," Tr. 509, his testimony is belied by the evidence that upon being served with the Immediate Suspension Order, he stated his intention not to comply with it. Indeed, his testimony is patently disingenuous, given that he wrote the prescriptions only two days after he was served with the Order. In short, Respondent's conduct manifests a deliberate and egregious disregard for his obligations as a DEA registrant.

Finally, while the ALJ noted that "Respondent testified passionately about the prevalence of narcotic abuse in Red Bay and his want to eliminate it," she further concluded that he "likely facilitated some of that abuse." Id. The ALJ's conclusion is well supported. Indeed, as found above, in numerous instances, Respondent issued controlled-substance prescriptions for the purported purpose of treating a patient's pain, even though he recorded in the patient's chart that the patient had "NO" pain and/or failed to make the findings required under the State's Guidelines to properly diagnose the patient. Moreover, during one of the interviews by the Investigators, Respondent admitted that he did not follow the State's Guidelines. Tr. 220. Respondent, however, offered no evidence that he now intends to comply with the Guidelines.

Accordingly, I hold that Respondent has not rebutted the Government's prima facie case. I will therefore order that Respondent's registration be revoked and that any pending application be denied. For the same reasons that led me to order the Immediate Suspension of Respondent's registration, I conclude that the public interest requires that this Order be effective immediately.

ORDER

Pursuant to the authority vested in me by 21 U.S.C. §§ 823(f) & 824(a)(4), as well as by 28 CFR 0.100(b) & 0.104, I order that DEA Certificate of Registration, BC1701184, and Identification Number XC1701184, issued to Morris W. Cochran, M.D., be, and they hereby are, revoked. I further order that any application for renewal or modification of such registration be, and it hereby is, denied. This Order is effective immediately.

Dated:
March 16, 2012

Michele M. Leonhart
Administrator

[FR Doc. 2012-7107 Filed 03/23/2012 at 8:45 am; Publication Date: 03/26/2012]